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New Patient Intake Form

SECTION 1: IDENTIFICATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Referred by: _____

Preferred Phone Number
_____(Cell / H / W)
OK to leave message? □ yes □ no

Backup Phone Number
_____(Cell / H / W)
OK to leave message? □ yes □ no

Do you want contact via e-mail? □ yes □ no
E-mail Address: _____
*Please note that e-mail correspondence is not considered to be a confidential medium of communication.

Emergency Contact: _____ _____
Name / Relationship Telephone (Cell / H / W)

Person completing this form (if other than patient):_____

SECTION 2: DEMOGRAPHICS

1. What is your age? _____

2. What is your date of birth? _____-_____-_____
(month - day - year)

3. What is your gender? Male Female Other_____

4. What is the highest level of education you attained?
   (1) Elementary school or middle high/junior high school
   (2) Graduated from high school or received G.E.D.
   (3) Received vocational/technical training
   (4) Some college
   (5) Graduated from a 4-year college
   (6) Received a master's or post-graduate degree
   (7) Received a doctoral degree (Ph.D., M.D.)

5. What is your religious/spiritual background, if any? (optional)
   (1) Jewish
   (2) Catholic
   (3) Protestant
   (4) LDS (Mormon)
   (5) Unitarian
   (6) Muslim
   (7) Atheist / Agnostic
   (8) Other (please specify):_____

6. Are you a full-time student: □ Yes □ No Year/Grade in school: _____
   Major (if applicable): _____

7. Are you employed: □ Yes □ No Occupation: _____
   How long in this position? _____ Do you enjoy your work? □ Yes □ No

8. Current Relationship Status: (circle and add date of event where applicable)
   Never Married _____ Married _____ Domestic Partnership _____ Widowed _____
   Divorced _____ Separated _____ Engaged _____ Other _____
   How long together _____
   Relationship Satisfaction (please circle): 1----------2----------3----------4----------5
   Poor Excellent

9. Do you have children? □ Yes □ No How many? ____ Ages: ____ ____ ____ ____

10. Who else lives in the home (family members or others)?

Name	Relationship to you	Age	Date of Birth	Gender
Name	Relationship to you	Age	Date of Birth	Gender
Name	Relationship to you	Age	Date of Birth	Gender
Name	Relationship to you	Age	Date of Birth	Gender

11. Please describe your reasons/goals for requesting services (be as specific as possible):

_____
_____
_____
_____
_____
_____
_____

SECTION 3: MENTAL HEALTH HISTORY

1. Which of the following kinds of psychological/psychiatric services have you received prior to coming here? PLEASE CIRCLE ALL THAT APPLY.
   (1) None (3) Partial care (5) Other 24-hour care
   (2) Outpatient therapy (4) Inpatient care

For each of the psychological/psychiatric services you indicated, please list the beginning and ending dates you received that treatment:

_____
_____
_____
_____

2. How many times have you received psychological/psychiatric services prior to coming here?
   (1) None (2) 1 – 2 (3) 3 – 4 (4) 5 or more, but fewer than 10 (5) 10 or more

3. Have you experienced any of the following problems? PLEASE CIRCLE ALL THAT APPLY.

(1) Anxiety
(2) Depression
(3) Extreme mood swings
(4) Alcohol or drug abuse
(5) Unusual thought or beliefs
(6) Learning disability
(7) Self-inflicted pain or injury
(8) Social isolation
(9) No appetite
(10) Always tired
(11) Unable to relax
(12) Recurrent dreams
(13) Hallucinations
(14) Feel tense
(15) Fears and phobias
(16) Suicidal ideas
(17) Can't make friends
(18) Poor living conditions
(19) Always worried about something
(20) Can't make decisions
(21) Financial problems
(22) Job problems
(23) Other _____
(24) Victim of abuse
(25) Eating disorder
(26) Criminal behavior/incarceration
(27) Aggression/violence
(28) Overwhelming crisis
(29) Recurrent conflicts with others
(30) Sexual problems
(31) Anger/Hostility
(32) Over-eating
(33) Always sleepy
(34) Insomnia
(35) Nightmares
(36) Inferiority feelings
(37) Feel panicky
(38) Obsessions
(39) Shy with people
(40) Afraid of people
(41) Unable to have a good time
(42) Don't like weekends/vacations
(43) Over-ambitious
(44) Gambling
(45) Can't keep a job

4. Have you ever engaged in self-injurious behavior? Yes ☐ No ☐
   If so, what?_____ If so, when and how often?_____

5. If you have ever attempted suicide, when did your most recent attempt occur?
   (1) I have never attempted suicide
   (2) Within the last month
   (3) More than 1 month ago, but within the last year
   (4) More than 1 year ago, but less than 5 years ago
   (5) More than 5 years ago

6. Has any other member of your family previously sought or received psychological or psychiatric counseling? Yes ☐ No ☐

7. Please circle below items if a family member has a current diagnosis, history, or if there is a family history of any of the following conditions. List family member affected, (father, mother, brother, sister, grandparent, uncle, aunt etc.).

	Family Member
Alcohol/Substance Abuse/Dependence	
Anxiety	
Depression	
Domestic Violence	
Eating Disorder	
Obsessive Compulsive Disorder	
Schizophrenia	
Bipolar Disorder	
Suicide Attempts	
ADHD	
Other	

8. Do you currently or have you ever used illegal drugs or misuse(d) prescription medications?
   Yes ☐ No ☐
   If yes, please state when, how much, and if you have received treatment:

_____
_____
_____
_____

SECTION 4: MEDICAL HISTORY

1. Have you had a physical examination within the last six months? Yes ☐ No ☐

2. Have you seen a physician or other health care professional within the last six months for reasons other than a physical checkup? Yes ☐ No ☐

   If yes, please specify reason(s): _____

   _____

3. Please circle any of the following that you have experienced either currently or in the past:

   (1) Headaches
   (2) Dizziness
   (3) Fainting spells/blackouts
   (4) Severe or prolonged nausea
   (5) Seizures or convulsions
   (6) Memory loss
   (7) Allergies
   (8) Asthma
   (9) Ulcers
   (10) High blood pressure
   (11) Thyroid difficulties
   (12) Diabetes
   (13) Hypoglycemia (low blood sugar)
   (14) Heart disease
   (15) Other heart condition (e.g., heart murmur, mitral valve prolapse
   (16) Gastrointestinal issues (specify):_____

4. How many serious injuries (that needed medical attention) have you had?

   _____

   _____

   _____

5. How many surgeries have you had? _____

6. Please describe major illnesses, surgeries and/or serious injuries and dates:

   _____

   _____

   _____

7. Are you currently taking prescription medications? Yes ☐ No ☐ If yes, please list:

Medication	Dose	Reason for taking

8. List any over the counter medications you currently take, including vitamins/supplements:

Over The Counter Vitamin/Supplement/Medicine	Dose	Reason for taking

9. Do you currently, or have a history of using substances/alcohol? Yes ☐ No ☐ If yes, list:

Substance / Alcohol	How much in one sitting?	How often per day, week or month?

10. Have there been changes in your sleeping patterns in the past three months? Yes ☐ No ☐
If yes, describe :
_____

11. Are you experiencing difficulty with appetite or changes in eating patterns? Yes ☐ No ☐
If yes, describe :
_____

12. Have you ever experienced domestic violence, abuse, or other violence in adulthood?
Yes ☐ No ☐ N/A ☐
If yes, please explain:
_____

13. Have you experienced abuse in childhood? PLEASE CIRCLE ALL THAT APPLY.
physical emotional verbal sexual mental neglect abandonment bullied
other (explain below)
_____
_____
_____
_____

14. Are you currently, or have you ever physically harmed another person? Yes ☐ No ☐
If yes, explain:
_____

15. Are you currently involved in legal proceedings? Yes ☐ No ☐
If yes, explain:
_____

16. Do you ever see or hear things other people say they can't see or hear?
If yes, please explain:

_____

17. Have you experienced significant life changes or stressful events recently?
If yes, please explain:

_____

18. Who is currently monitoring your medication (if any) for psychological problems?
_____ Phone:_____
May I contact this physician? Yes ☐ No ☐ (If 'Yes' please sign consent)

19. If there are any other medical or physical problems, which you feel might be important to my ability to be of help to you, please explain here:

_____

20. Who is your current physician? _____ Phone:_____
May I contact this physician? Yes ☐ No ☐ (If 'Yes' please sign consent)

SECTION 5: EATING AND WEIGHT HISTORY

Please carefully complete all questions, choosing NO or 0 for questions that do not apply.

Over the past 3 months… Not at all / Slightly / Moderately / Extremely

1. Have you felt fat?. 0 1 2 3 4 5 6

2. Have you had a definite fear that you might gain weight or become fat?. 0 1 2 3 4 5 6

3. Has your weight or shape influenced how you judge yourself as a person?. 0 1 2 3 4 5 6

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4. During the past 3 months have there been times when you have eaten what other people would regard as an unusually large amount of food (e.g., a pint of ice cream) given the circumstances?. . . . . YES NO

5. During the times when you ate an unusually large amount of food, did you experience a loss of control (e.g., felt you couldn't stop eating or control what or how much you were eating?. . . . . .YES NO

6. How many times per month on average over the past 3 months have you eaten an unusually large amount of food and experienced a loss of control? 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

During episodes of overeating with a loss of control, did you...

7. Eat much more rapidly than normal?. . . . . YES NO

8. Eat until you felt uncomfortably full?. . . . . YES NO

9. Eat large amounts of food when you didn't feel physically hungry? . . . . . YES NO

10.Eatalonebecauseyouwereembarrassedbyhowmuchyouwereeating? . . . . . .YES NO

11. Feel disgusted with yourself, depressed, or very guilty after overeating? . . . . . .YES NO

12. If you have episodes of uncontrollable overeating, does it make you very upset? . . . . . .YES NO

In order to prevent weight gain or counteract the effects of eating, how many times per month on average over the past 3 months have you:

13. Made yourself vomit?. . . . . 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

14. Used laxatives or diuretics?. . . . . .0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

15. Fasted (skipped at least 2 meals in a row)? . . . . . .0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

16. Engaged in more intense exercise specifically to counteract the effects of overeating?. . . . . 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

17. How many times per month on average over the past 3 months have you eaten after awakening from sleep or eaten an unusually large amount of food after your evening meal and felt distressed by the night eating? . . . . . 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

18. How much do eating or body image problems impact your relationships with friends and family, work performance, and school performance? Not at all / Slightly / Moderately / Extremely 0 1 2 3 4 5 6

19. How much do you weigh? If uncertain, please give your best estimate. _____lbs.

20. How tall are you? _____ft. _____in.

21. What is your highest weight at your current height? _____lbs.

22. What is your sex? MALE FEMALE

23. What is your age? _____

1. Weight History

Current weight _____ Current height _____ Desired Weight_____

Highest Adult weight _____ At what age?_____

Lowest Adult weight _____ At what age? _____

At your current weight, how do you feel? _____

2. Diet History

Have you ever been on a diet? If yes, describe: _____

_____

At what age did you go on your first diet? _____

Last year, how many times did you start a diet? _____

Describe your most common diet methods:

_____
_____
_____
_____
_____

3. Binge Eating

Have you ever had episodes of eating large amounts of food in short periods of time?_____

Put a checkmark beside statements that describe your binge eating behaviors:

____ I consume large amounts of food

____ I eat rapidly.

____ I feel out of control during binges.

____ I get uncontrollable urges to eat

____ I eat until I'm physically ill.

____ I binge alone.

____ I binge with others.

How long does a binge usually last? _____What time of day do you usually binge?_____

Describe any emotions or thoughts that might trigger a binge.

_____
_____

How long have you had a problem with binge eating? _____ Since what age?_____

Has there been a time since binge eating started that you were able to stop binging?_____

If so, what were the circumstances?

_____
_____

4. Purging Behavior

Have you ever self-induced vomiting in order to get rid of food? _____

How old were you the first time? ____How long have you engaged in purging behavior? _____

What method do you use to induce vomiting? _____ Have you ever used laxatives to control your weight? _____ How old were you the first time? _____

How long have you been using laxatives to control your weight? _____ What is the average number of laxatives you use in a week? _____

Over the past month, what has been the average number of times you have engaged in the following behaviors per week?

_____Binge eating

_____ Vomiting

_____ Use of laxatives

_____ Use of diet pills

_____ Use of enemas

_____ Fasting the entire day

_____ Fasting a partial day

_____ Exercising more than 1 hour a day

Over the past month, on the average, how many times per week have you been able to eat a regular meal and not purge in any way? _____

5. Physical Symptoms of an Eating Disorder

Check all of the symptoms that you have experiences as a result of your eating disorder

_____ Sore throat

_____ Weakness

_____ Feeling bloated

_____ Stomach pains

_____ Intolerance to cold

_____ Missed menstrual period

_____ Overly sensitive to light

_____ Growth of hair

_____ Muscle spasms

_____ Fainting or dizzy spells

_____ Swollen glands

_____ Constipation

_____ Water retention

_____ Feelings of confusion

_____ Hair loss

_____ Dental problems