

admissions INTAKE INFORMATION

Your answers to the following questions will better prepare us to support you when you arrive. In addition, the Medical Form **MUST** be completed by your current physician. Please fax or mail both forms to us prior to your admission.

NAME _____

PHONE (HOME) _____ (CELL) _____ EMAIL ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CURRENT WEIGHT _____ USUAL WEIGHT _____ HEIGHT _____

CARDIO (HOURS/WEEK) _____ WEIGHT TRAINING (HOURS/WEEK) _____ SPORT OR LIGHT EXERCISE (HOURS/WEEK) _____

ACTIVE PROBLEMS CHECK ALL THAT APPLY

- EATING LESS THAN 1000 CALORIES A DAY
- BINGE EATING
- EXTREME RIGIDITY IN EATING
- COMPULSIVE EXERCISE
- LOW WEIGHT

- AVOIDANCE OF FAT
- AVOIDANCE OF PROTEIN
- AVOIDANCE OF CARBS
- AVOIDANCE OF FLUID
- VOMITING
- AMMENORHEA (ABSENCE OF, OR INFREQUENT MENSTRUAL PERIODS)

- DIURETICS
- APPETITE SUPPRESSANTS
- FAT ABSORBERS
- LAXATIVES (MORE THAN ONCE A WEEK)
- INTERNET USE
- STEROID USE

MEDICAL SIGNS/COMPLICATIONS CHECK ALL THAT APPLY

- CONSTIPATION
- REFLUX, HEARTBURN
- EDEMA (SWELLING)
- ABNORMALITIES IN SODIUM
- ABNORMALITIES IN POTASSIUM
- ABNORMALITIES IN PHOSPHORUS
- BRADYCARDIA (SLOW PULSE BELOW 50 B/M)

- LOW BODY TEMPERATURE (BELOW 97°)
- FAINTING
- OSTEOPENIA, OSTEOPOROSIS (BONE LOSS)
- LANUGO (FINE FACIAL HAIR ASSOCIATED WITH MALNUTRITION)
- HAIR LOSS
- NIGHT SWEATS
- OTHER _____

OTHER COMMON PROBLEMS CHECK ALL THAT APPLY

- DEPRESSION
- MANIAS, MOOD SWINGS
- ATTENTION DEFICIT DISORDER
- ANXIETY (PANIC, SHYNESS, AVOIDANCE, WORRY)
- OBSSIVE COMPULSIVE DISORDER
- SELF HARMING BEHAVIOR (SUCH AS CUTTING)
- PAST SUICIDE ATTEMPTS

- CHRONIC THOUGHTS OF SUICIDE
- PERFECTIONISM
- ADDICTIVE BEHAVIOR (ALCOHOL, MARIJUANA, COCAINE)
- BODY DISSATISFACTION
- SEXUAL COMPULSIVITY
- LACK OF SEXUAL DESIRE
- PROBLEMS WITH HOARDING

- STEALING OR SHOPLIFTING
- SOCIAL ISOLATION
- TROUBLE WITH WORK
- TROUBLE WITH SCHOOL
- MEMORY PROBLEMS
- HOARDING OF FOOD OR CONDIMENTS

PAST TRAUMAS CHECK ALL THAT APPLY

- VICTIM OF ASSAULT
- DIFFICULT CHILDHOOD
- LOSS OF PARENT OR SIBLING
- OTHER _____

PLEASE COMPLETE ADDITIONAL INFORMATION ON THE OTHER SIDE OF THIS FORM.

PAST TREATMENTS

RESIDENTIAL CENTERS (Places & Dates) _____

INPATIENT TREATMENTS (Places & Dates) _____

DAY TREATMENTS (Centers & Dates) _____

PSYCHOTHERAPY

DESCRIBE PAST INDIVIDUAL, GROUP & FAMILY TREATMENTS (Places & Dates)

CURRENT MEDICATIONS/DOSES

ANY OVER THE COUNTER MEDICATIONS OR BIRTH CONTROL PILLS? NO YES, _____

ALLERGIES: _____

MEDICAL HISTORY

OTHER MEDICAL PROBLEMS

DATE OF LAST

 / / / / / / / / / /
PHYSICAL EXAM MENSES PELVIC EXAM DENTAL EXAM DEXA BONE SCAN

CURRENT THERAPIST

PSYCHIATRIST

INTERNIST

NAME _____

NAME _____

NAME _____

PHONE NUMBER _____

PHONE NUMBER _____

PHONE NUMBER _____

PLEASE DESCRIBE BRIEFLY YOUR GOALS FOR RECOVERY & YOUR LEVEL OF MOTIVATION FOR CHANGE:

PLEASE DESCRIBE ANYTHING YOU KNOW ABOUT YOURSELF THAT MAY INTERFERE WITH YOUR ABILITY TO BENEFIT FROM TREATMENT:
