

## INTAKE QUESTIONNAIRE

NAME \_\_\_\_\_

### WHY TREATMENT NOW? IMPACT OF PRIOR TREATMENT EXPERIENCES

TELL US WHY YOU ARE PURSUING TREATMENT AT THIS TIME:

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\_\_\_\_\_

WHAT ASPECTS OF BEING IN TREATMENT CONCERN YOU?

\_\_\_\_\_

\_\_\_\_\_

IF YOU HAVE BEEN IN TREATMENT PREVIOUSLY, WHAT ARE SOME OF THE POSITIVE OR NEGATIVE EXPERIENCES THAT MAY IMPACT YOUR EXPERIENCE AT OLIVER-PYATT CENTERS?

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\_\_\_\_\_

### LIFE SITUATION

CURRENT LIVING AND SOCIAL ENVIRONMENT (*WHO YOU LIVE WITH / SETTING YOU LIVE IN*):

\_\_\_\_\_

\_\_\_\_\_

HOW DO YOU FEEL YOUR CURRENT LIVING ENVIRONMENT IMPACTS YOU?

\_\_\_\_\_

\_\_\_\_\_

WHO IS IN YOUR SUPPORT SYSTEM (*E.G., FAMILY, FRIENDS, THERAPIST*)?

\_\_\_\_\_

\_\_\_\_\_

CAN YOU DESCRIBE A TYPICAL OR RECENT DAY IN YOUR LIFE THAT WOULD HELP US UNDERSTAND YOU?

\_\_\_\_\_

\_\_\_\_\_



**ADDITIONAL BACKGROUND INFORMATION**

ARE YOU INVOLVED IN ANY SPORTS OR EXERCISE?

WHAT MOTIVATES / MOTIVATED YOU TO PARTICIPATE IN SPORTS OR EXERCISE?

DO YOU HAVE ANY PARTICULAR INTERESTS, PASSIONS, OR HOBBIES THAT YOU CAN TELL US ABOUT?

DO YOU HAVE ANY DIETARY REQUIREMENTS DUE TO RELIGION (E.G., KOSHER) OR MEDICAL CONDITION YOU HAVE DOCUMENTATION FOR (E.G., DIABETES, FOOD ALLERGIES)?

HAVE YOU BEEN FED BY NON-ORAL ROUTES AND / OR RECEIVED SUPPLEMENTS AS YOUR PRIMARY SOURCE OF NUTRITION? IF SO, PLEASE PROVIDE DETAILS:

HAVE YOU HAD ANY TYPE OF GI SURGERY (E.G., GASTRIC BYPASS, RESECTIONING)? IF SO, PLEASE PROVIDE DATE(S) AND OUTCOME:

DID YOU EXPERIENCE AN OUTCOME THAT YOU FELT WAS POSITIVE OR NEGATIVE WITH REGARD TO YOUR PHYSICAL AND / OR EMOTIONAL HEALTH? IF SO, PLEASE DESCRIBE:

**EATING DISORDER SYMPTOMS**

HEIGHT CURRENT WEIGHT

USUAL WEIGHT DESIRED WEIGHT

HIGHEST WEIGHT/AGE LOWEST WEIGHT/AGE

WEIGHT BEFORE ONSET OF EATING DISORDER/AGE

RECENT WEIGHT CHANGES (DESCRIBE WEIGHT LOSS OR GAIN PATTERNS OVER THE PAST 12 MONTHS)

CURRENT CALORIC INTAKE (INCLUDING SUPPLEMENTS)

DO YOU RESTRICT YOUR FOOD INTAKE?

NO  YES, BUT ONLY IN THE PAST (WHEN DID YOU STOP?)

YES, I CURRENTLY RESTRICT

IF YES, HOW DO YOU / DID YOU RESTRICT (E.G., CALORIES, FASTING, SPECIFIC FOOD AVOIDANCE)?



DO YOU BINGE EAT? (BINGE EATING IS DEFINED AS EATING AN AMOUNT OF FOOD THAT IS LARGER THAN THE AVERAGE PERSON WOULD CONSUME, ACCOMPANIED BY A SENSE OF BEING OUT OF CONTROL.)

NO  YES, BUT ONLY IN THE PAST (WHEN DID YOU STOP?)  YES, I CURRENTLY BINGE

IF YES, HOW OFTEN DO YOU /DID YOU BINGE PER DAY /WEEK ON AVERAGE?

DO YOU HAVE OTHER OVER-EATING PATTERNS SUCH AS "GRAZING" ON FOOD ALL DAY?

WHAT ARE YOUR PREFERRED BINGEING AND /OR GRAZING FOODS?

DO YOU PURGE?

NO  YES, BUT ONLY IN THE PAST (WHEN DID YOU STOP?)  YES, I CURRENTLY PURGE

IF YES, HOW OFTEN DO YOU /DID YOU PURGE PER DAY /WEEK ON AVERAGE?

DO YOU ABUSE LAXATIVES?

NO  YES, BUT ONLY IN THE PAST (WHEN DID YOU STOP?)  YES, I CURRENTLY ABUSE

IF YES, WHAT KIND OF LAXATIVES DO YOU /DID YOU USE, AND WHAT AMOUNT PER DAY /WEEK ON AVERAGE?

DO YOU CURRENTLY USE WEIGHT-LOSS PILLS?  NO  YES

IF YES, LIST TYPE, QUANTITY, AND FREQUENCY

DO YOU DRINK AN EXCESSIVE AMOUNT OF WATER?  NO  YES

DO YOU HAVE ANY FOOD RITUALS THAT CONCERN YOU?  NO  YES

IF YES, PLEASE EXPLAIN:

DO YOU HAVE AN UNHEALTHY RELATIONSHIP WITH EXERCISE?

NO

YES, I GET ANXIOUS OR IRRITABLE IF I CAN'T ENGAGE IN MY EXERCISE ROUTINE

YES, I OVER-EXERCISE (HOW MANY HOURS PER DAY /WEEK?)

YES, I EXERCISE AGAINST THE ADVICE OF A HEALTH CARE PROVIDER AND /OR DESPITE PAIN

YES, I UNDER-EXERCISE

**EXPOSURE TO TRAUMA**

HAVE YOU BEEN PHYSICALLY ABUSED?  NO  YES

HAVE YOU BEEN SEXUALLY ABUSED?  NO  YES

DOES ANYONE IN YOUR FAMILY STRUGGLE WITH SUBSTANCE ABUSE, A MENTAL HEALTH ISSUE, OR AN EATING DISORDER?  NO  YES

HAVE YOU LOST A CLOSE FAMILY MEMBER?  NO  YES

OTHER:



**PRIOR TREATMENT EXPERIENCES (LIST PLACES, DATES, AND HOW THEY IMPACTED YOU)**

INDIVIDUAL THERAPY

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INTENSIVE OUTPATIENT

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DAY TREATMENT/PARTIAL HOSPITALIZATION

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RESIDENTIAL

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INPATIENT PSYCHIATRIC

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INPATIENT MEDICAL

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**CO-OCCURRING CONDITIONS**

LET US KNOW IF YOU HAVE EVER BEEN DIAGNOSED WITH AND/OR HAVE EXPERIENCED ANY OF THE FOLLOWING CONDITIONS THAT SOMETIMES ACCOMPANY EATING DISORDERS:

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| DEPRESSION  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| BIPOLAR DISORDER / MANIA / HYPOMANIA / EXTREME MOOD FLUCTUATION         | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| PREMENSTRUAL SYMPTOMS   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| POSTMENOPAUSAL SYMPTOMS   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| ATTENTION DEFICIT DISORDER  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| PANIC DISORDER  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| SOCIAL PHOBIA   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| ANXIETY DISORDER  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| OBSESSIVE COMPULSIVE DISORDER   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| OTHER IMPULSIVE DISORDER (E.G., SHOPPING, SEXUAL IMPULSIVITY, GAMBLING) | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| EXCESSIVE/DISRUPTIVE USE OF INTERNET OR COMPUTER GAMES                  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| SUBSTANCE ABUSE   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| ALCOHOL ABUSE   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| HOARDING (OF FOOD OR POSSESSIONS)                                       | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| SHOPLIFTING OR STEALING   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| ANXIETY OR INABILITY TO SHOP FOR FOOD AND/OR CLOTHING                   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| ANXIETY OR INABILITY TO EAT IN RESTAURANTS OR TAKE-OUT FOODS            | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| OTHER:  |                             |                              |
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**SELF-HARM**

DO YOU HAVE SUICIDAL THOUGHTS?  NO  YES

HAVE YOU EVER TRIED TO COMMIT SUICIDE?  NO  YES

IF YES, HOW AND WHEN? \_\_\_\_\_

DO YOU DO OTHER SELF-HARMING BEHAVIORS (E.G., CUTTING, BURNING, PICKING)?  NO  YES

IF YES, WHERE ON YOUR BODY? \_\_\_\_\_

CAN YOU COMMIT TO SAFETY WHILE UNDER THE CARE OF OLIVER-PYATT CENTERS?  NO  YES

**PSYCHIATRIC MEDICATION HISTORY**

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST? (PROVIDE WHATEVER INFORMATION YOU REMEMBER)

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSE \_\_\_\_\_ DURATION \_\_\_\_\_

**MEDICAL HISTORY**

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

CURRENT MEDICAL CONDITIONS \_\_\_\_\_

CURRENT MEDICATIONS FOR ANY MEDICAL CONDITIONS \_\_\_\_\_

AGE OF ONSET OF MENSES / LAST MENSTRUAL PERIOD \_\_\_\_\_

PAST AND/OR RESOLVED MEDICAL CONDITIONS \_\_\_\_\_

PAST MEDICAL HOSPITALIZATIONS \_\_\_\_\_

SERIOUS INJURIES TO THE SPINE OR HEAD \_\_\_\_\_



**ADDITIONAL INFORMATION**

YOU MAY EXPERIENCE PERSONAL STRUGGLES DURING YOUR TREATMENT. DO YOU FEEL IT WILL BE DIFFICULT TO SHARE THOSE STRUGGLES WITH US? IF SO, PLEASE EXPLAIN:

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PLEASE LIST THREE PROMINENT STRESSORS YOU HAVE AT THIS TIME:

1. 

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2. 

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3. 

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WHAT ARE SOME STRENGTHS AND WEAKNESSES YOU HAVE THAT MAY INFLUENCE THE COURSE OF YOUR TREATMENT?

*STRENGTHS:*

*AREAS OF STRUGGLE:*

1. <hr/>	1. <hr/>
2. <hr/>	2. <hr/>
3. <hr/>	3. <hr/>

**PROSPECTIVE CLIENT**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PHONE \_\_\_\_\_

**OLIVER-PYATT CENTERS STAFF**

NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_