| Date: (yy/mm/dd) | | | | | | | | | Name of Individual: Last, First | | | | | | | | | | | | | | CID: | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CLIENT/PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Health Card #: | | | | |  | | | | | | | | | | | | VC: | |  | | | | | | | | | | | |
| (H) Phone #: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| (C) Phone #: | | | | |  | | | | | | | | | | | Ok to text | | | | | | | | | | | | | | |
| Email: | | | | |  | | | | | | | | | | | *\*Eating Disorders Intake will follow-up email.* | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUIRED ELIGIBILITY CHECKLIST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child/Adolescents (6-18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Resident of Waterloo Region or Wellington County | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Medically fit to engage in treatment services in a community-based setting | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Not actively psychotic or suicidal | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Prepared to be medically monitored by physician or nurse practitioner | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adults (18+) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Resident of Waterloo Region, Wellington County | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Medically fit to engage in treatment services in a community-based setting | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Not actively psychotic or suicidal | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Prepared to be medically monitored by physician or nurse practitioner | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DETAILED PRESENTING ISSUES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Purging | | | | | | | | | | | | | Frequency: | | | | |  | | | | | Duration: | | | |  | |
|  | | Laxatives | | | | | | | | | | | | | Frequency: | | | | |  | | | | | Duration: | | | |  | |
|  | | Binging | | | | | | | | | | | | | Frequency: | | | | |  | | | | | Duration: | | | |  | |
|  | | What does a typical binge look like? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | When you are binging are you eating until you feel nauseous? | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
|  | | Restricting | | | | | | | | | | | | | Frequency: | | | | |  | | | | | | | | | | |
|  | | How many meals/day? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | What food are you avoiding? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | Exercising | | | | | | | | | | | | | Frequency: | | | | |  | | | | | | Duration: | | | |  |
| How many calories are you eating per day? | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Are you currently using a weight loss program? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Are you hoarding or hiding food? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| MEDICAL CONCERNS/BODY IMAGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you currently trying to lose weight? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| What is your height? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| What is your current weight? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| What is your ideal weight? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Are you losing/gaining weight or is your weight stable? | | | | | | | | | | | | | | | | | | | | Losing/Gaining  Stable | | | | | | | | | | |
|  | For how long? | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Do you experience fainting or dizziness? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Do you have diabetes? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Do you have any heart issues? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Do you have menstrual cycle concerns? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
| Do you experience constipation? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| SUBSTANCE USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Which of the following do you currently use? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cigarettes | | | | | | | Alcohol | | | | | | | | | Diet Pills | | | | | | | | | | | | | | |
| Drugs | | | | Please specify what kind of drugs: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PSYCHIATRIC HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you previously received counselling? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | When: | | | | | | | | | Where: | | | | | | | | | | | | | | | | | | |
|  | | | Was it for an eating disorder? | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you previously been hospitalized for a mental health concern? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Type | | | | | | Date | | | | | | | Duration | | | | | Facility | | | | | | | | | | Reason | | |
| Emergency Department | | | | | |  | | | | | | |  | | | | | Choose an item. | | | | | | | | | |  | | |
| Admission | | | | | |  | | | | | | |  | | | | |
| Emergency Department | | | | | |  | | | | | | |  | | | | | Choose an item. | | | | | | | | | |  | | |
| Admission | | | | | |  | | | | | | |  | | | | |
| Emergency Department | | | | | |  | | | | | | |  | | | | | Choose an item. | | | | | | | | | |  | | |
| Admission | | | | | |  | | | | | | |  | | | | |
| Are you currently involved with other mental health services (i.e. EAP, FHT, private)? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| FAMILY HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Does anyone in your family have a history of mental health concerns? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | If yes, please describe: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Does anyone in your family have a history of substance abuse concerns? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | If yes, please describe: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Is there any history of family violence? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | If yes, please describe: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Did your family receive counselling for this? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Does anyone in your family have a history of eating disorders? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | If yes, please describe: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Is there any history of domestic violence? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
|  | | | If yes, please describe: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | Did you receive counselling for this? | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| MEDICAL INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Card Provider: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Is your primary care provider aware of your concerns/this referral? | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| ADDITIONAL QUESTIONS FOR CHILD/ADOLESCENT REFERRALS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the family composition *(who do they live with, who has custody, siblings in home)?* | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Are they exhibiting any behaviours? *(i.e. Are they chewing and then spitting food?)* | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Do they chew gum? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | |
|  | If yes, how many packs per day? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What has been their highest weight? | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Are they experiencing any hair loss? | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Not sure | | | | | | | |
| Are they having any chest pain? | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Not sure | | | | | | | |
| PARENT/GUARDIAN INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian #1 Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| (H) Phone #: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| (C) Phone #: | | | | | | | |  | | | | | | | | | | | | | | | | Ok to text | | | | | | |
| Email: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian #2 Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| (H) Phone #: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| (C) Phone #: | | | | | | | |  | | | | | | | | | | | | | | | | Ok to text | | | | | | |
| Email: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Completed by: | | | | | | | | | | | | | | | | | | | | | Position: | | | | | | | | | |