| 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:       |