ED Group Intake Form

(All information on this form is strictly confidential)

Name: _____ Gender: _____
Date of Birth: _____ Age: _____
Home Address: _____ Phone: _____
E-mail Address:_____
May your therapist contact you via (please select "yes" on at least one):
Phone call? □ Yes □ No Text message? □ Yes □ No
E-mail? □ Yes □ No Voicemail message? □ Yes □ No

Emergency Contact Name: _____Relationship:_____
Phone: _____
Primary Care Physician Name: _____Phone:_____

Medical History

Allergies: _____
Height: _____ Current Weight:_____
List of current medications, dosage, and response/ side-effects (if any):
_____
_____
List of current medical problems (if any):
_____
_____

Briefly describe what you are seeking to get from group therapy: _____
_____
_____

Relationship Status

___Single___Married___Living with partner___Separated/Divorced
___Widowed ___In a relationship ___Other_____
Have you ever been in an abusive relationship? ___Yes ___No
If so, what was your role in the abuse? ___Victim ___Abuser ___Both
What kind of abuse? ___emotional ___physical ___sexual ___other_____
Are you currently in an abusive relationship? ___Yes ___No
Do you feel safe? ___Yes ___No
Comments about past/present relationship(s) (optional):_____
_____
_____

Mental Health History

(please check all that apply)

___Abuse/trauma – physical, sexual, emotional, neglect
___Aggression, violence
___Anger, hostility, arguing, irritability
___Anxiety, nervousness
___Attention, concentration, distractibility
___Career concerns, goals, and choices
___Childhood issues
___Compulsions and/or obsessions (thoughts or actions that repeat themselves)
___Delusions (false ideas)
___Depression, low mood, sadness, crying
___Drug abuse – prescription medications, over-the-counter medications, alcohol, street drugs
___Eating problems – overeating, undereating, appetite, vomiting
___Fatigue, tiredness, low energy
___Fears, phobias
___Financial or money troubles, debt, impulsive spending, low income
___Grieving, mourning, deaths, losses, divorce
___Guilt
___Headaches, other kinds of pains
___Health, illness, medical concerns, physical problems (please explain) _____
___Impulsiveness, loss of control, outbursts
___Loneliness
___Memory problems
___Mood swings
___Panic or anxiety attacks
___Perfectionism
___Relationships problems (with friends, with relatives, or at work)
___Self-esteem
___Self-neglect, poor self-care
___Sleep problems (too much, too little, insomnia, nightmares)
___Spiritual, religious, moral, ethical issues
___Suicidal thoughts
___ Work problems, employment issues
___Other_____

ED History

(Please check all that apply in the past 6 months)

___Restrivtive eating
    If so, how many times a week do you restrict? _____
    How long have you engaged in this behavior for?_____
___Binge eating
    If so, how many times a week do you binge? _____
    How long have you engaged in this behavior for?_____
___Self-induced vomiting
    If so, after every meal? _____ How often?_____
    How long have you engaged in this behavior for?_____

___Over-exercise
If so, how often?_____
How long have you engaged in this behavior for?_____
___Use of diet pills, laxatives, or diuretics
If so, how often?_____
How long have you engaged in this behavior for?_____
___Body dysmorphia (seeing a reflection of your body that does not match watch others seem to see)
___Self-esteem/worth dependent on body shape or size
___Food tasting and spitting
___Calorie counting
___Negative internal voice
___Avoiding eating with others
___Elaborate food rituals
___Eating in secret
___Extreme anxiety when routine is broken
___People pleasing

Please check the levels of mental health treatment that you have engaged in during your lifetime:
If checked, please indicate approximate timeframe and reason for treatment:
___Residential treatment/Hospitalization _____
___Partial Hospitalization treatment _____
___Intensive Outpatient treatment _____
___Outpatient treatment _____

Suicide Risk Assessment
Have you ever had any suicidal thoughts or wish you could go to sleep and not wake up?___Yes___No
If yes, have you had these thoughts in the past month?___Yes___No
Have you had thoughts about killing yourself with a plan?___Yes___No
If yes, please describe_____
Have you had these thoughts in the past month?___Yes ___No
Are you currently experiencing suicidal ideation? ___Yes ___No
If yes, have you started to work out or worked out the details of how to kill yourself?___Yes ___No
Do you intend to carry out this plan?___Yes ___No
Please describe_____
What is the single, most important aspect or person in your life worth living for? _____
_____

Educational History
Highest Grade Completed? _____ Where?_____
Did you attend college? _____ Where? _____
Major? _____
What is your highest educational level or degree attained?
_____

Occupational History
Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired
How long in current position? _____
What is/was your occupation? _____
Where do you work? _____

Have you ever served in the military? □ Yes □ No
If yes, what branch and when? _____ Honorable discharge? □ Yes □ No
Other type discharge_____

Legal History
Have you ever been arrested? □ Yes □ No If yes, when?_____
Reason:_____
Do you have any pending legal charges? □ Yes □ No
Are you currently on Parole or Probation? □ Yes □ No
If yes, until when?_____

Cultural and Spiritual Life
Please list any cultural, spiritual, or religious groups you identify with:
_____
_____
Do any of the above listed serve as a support or coping mechanism for you? □ Yes □ No
Do you need help coping with any cultural, religious, or spiritual aspect in your life? □ Yes □ No
If yes, please describe:_____
_____
Is there anything else you would like your therapist to know about you and/or your unique therapeutic needs?_____
_____
_____
_____
_____
_____

Thank you for taking the time to answer the above questions, these will help your therapist get a better idea of your individual therapeutic needs.