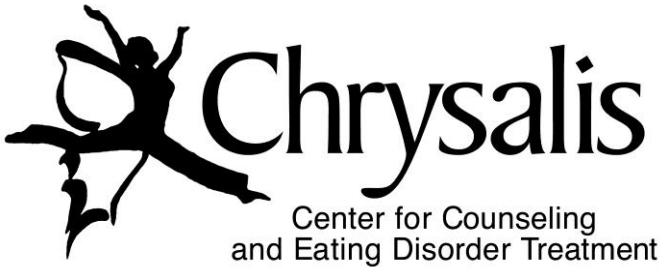

3240 Burnt Mill Drive ◇ Suite 1 ◇ Wilmington, NC 28403 ◇ Tel: 910-790-9500 ◇ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential.

Demographic Information:

Name: _____ SSN: _____ Date: _____

Mailing Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which phone is the best way to contact you? _____ Is it okay to leave a message? Yes No

_____	_____	_____	_____	_____
Date of Birth	Age	Sex	Ethnic Group	Religious Preference

Relationship Status:

Single _____ Cohabitating _____ Married _____ Separated _____ Divorced_____ Widowed _____

Emergency Contact: _____ Telephone: (_____) _____

Parent/Guardian Name (if relevant): _____

Address: _____ Telephone: (_____) _____

Referral Information:

How did you find out about our services? _____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing:

Education Information:
Highest Level of Education Completed:
Grade School _____ High School _____ College _____ Graduate School __

Are you currently a student? Yes No
If yes, where? _____ Year _____ Major _____

Family/Significant Others:
Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Job/ Highest Education Completed	Where He/She Lives	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

If anyone in your family has a history of the following, please check all that apply and specify on the chart above: Mental Illness ____ Substance Abuse ____ Eating Disorder ____ Obesity ____ Dieting ____

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities:_____
_____
_____

Allergies/Adverse Reactions to Treatment:_____
_____

Primary Care Physician Name: _____
Telephone: (_____) _____ Address: _____

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you)

_____Individual Counseling
_____ Group Counseling
_____ Couples/Family Counseling
_____ Nutritional Counseling
_____ Bariatric Evaluation
_____ Assessment

Mental Health History:

Have you received counseling before? Yes No

If yes, when, where, and with whom? _____

_____

Have you ever experienced any of the following?

_____ A recent and/or important loss (please specify)_____
_____ Physical Abuse
_____ Sexual Abuse/Molestation
_____ Sexual Assault
_____ Verbal/Emotional Abuse
_____ Suicidal Thoughts or Feelings
_____ Homicidal Thoughts or Feelings

Are you having current difficulties with any of the following?

_____ Self-Confidence/Self-Esteem
_____ Body Image
_____ Anger Management
_____ Peer Relationships
_____ Romantic Relationships
_____ Family Relationships
_____ Divorce/Separation
_____ Sexual Identity Issues
_____ Legal Problems
_____ Racial/Cultural Issues
_____ Other stress (please specify)_____
_____ Financial Problems
_____ Unemployment
_____ Learning Disabilities
_____ Loneliness/Social Isolation
_____ Career Planning
_____ Academic Performance
_____ Spirituality
_____ Decision Making
_____ Pregnancy (past, present)

How well are you getting along psychologically at this time?

_____ Very well, the way I want to.
_____ Quite well, no important complaints.
_____ Fairly well, but have ups and downs.
_____ So-so, can keep going with effort.
_____ Quite poorly, can barely manage.
_____ Very poorly, can't manage.

Instructions: The questions below ask about things that might have bothered you or caused problems. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**. If the problem has happened in the past, even if it is resolved, please check "In the past."

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**In the past**	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (office use only)
I.	Little interest or pleasure in doing things?		0	1	2	3	4	
	Feeling down, depressed, empty or hopeless?		0	1	2	3	4	
II.	Feeling more irritated, grouchy, or angry than usual?		0	1	2	3	4	
	Feeling more tired than usual for no reason?		0	1	2	3	4	
	How long do these feelings usually last?							
	What is the longest they have ever lasted?							
III.	Sleeping less than usual, but still have a lot of energy?		0	1	2	3	4	
	Starting more projects than usual or doing more risky things than usual?		0	1	2	3	4	
	Feeling unusually high, charged up, excited or restless?		0	1	2	3	4	
	Had other people ever said that you were too high, charged up, excitable, or talkative?		0	1	2	3	4	
	How long have these moods usually last?							
	What is the longest they have lasted?							
IV.	Feeling nervous, anxious, frightened, worried, or on edge for days at a time, even when you didn't have anything special to do?		0	1	2	3	4	
	Feeling panic or being frightened?		0	1	2	3	4	
	Avoiding situations that make you anxious?		0	1	2	3	4	
	Have these feelings ever bothered you on and off for six months or more at a time? If so, how long did they last and when did this occur?							
	Feeling very afraid of certain things like heights, animals, needles, the sight of blood, lightening, etc?		0	1	2	3	4	
	What were you afraid of?							
	Feeling so afraid to leave home by yourself that you wouldn't go out?		0	1	2	3	4	
	Feeling afraid to go to supermarkets, go into tunnels, or use elevators?		0	1	2	3	4	
	Feeling so afraid of embarrassing yourself in public that you would not do certain things like eating in a restaurant, using a public restroom, or speaking out in a room full of people?		0	1	2	3	4	
	Did you see a doctor because of this and if so, what did the doctor tell you about these symptoms?							
	Having a lot of physical problems that have forced you to see different doctors?		0	1	2	3	4	
V.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?		0	1	2	3	4	
	Feeling that your illnesses are not being taken seriously enough?		0	1	2	3	4	
	Doctors having difficulty finding what caused the		0	1	2	3	4	

	problems?							
	Did you start having any of these problems before you were 30 years old? How old were you?							
VI.	Thoughts of actually hurting yourself?		0	1	2	3	4	
VII.	Hearing things other people couldn't hear, such as voices even when no one was around?		0	1	2	3	4	
	Feeling that someone could hear your thoughts or that you could hear what another person was thinking?		0	1	2	3	4	
VIII.	Problems with sleep that affected your sleep quality over all?		0	1	2	3	4	
IX.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?		0	1	2	3	4	
	Having consistently had difficulty focusing and paying attention?		0	1	2	3	4	
	Feeling impatient, restless, and difficulty sitting still?		0	1	2	3	4	
	Others describing you as impulsive and/or hyper (e.g., do you tend to blurt out comments, interrupt others, say or do things you regret later)?		0	1	2	3	4	
X.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?		0	1	2	3	4	
	Feeling driven to perform certain behaviors or mental acts over and over again?		0	1	2	3	4	
	Doing things in an exact way or order even if it didn't make sense?		0	1	2	3	4	
XI.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?		0	1	2	3	4	
XII.	Not knowing who you really are or what you want out of life?		0	1	2	3	4	
	Not feeling close to other people or enjoying your relationships with them?		0	1	2	3	4	
	Being very worried or upset about something that happened to you, such as the death of a loved one, losing a job, getting separated or divorced, having a bad accident, getting a serious illness, etc.?		0	1	2	3	4	
	Having more trouble handling these situations than most people would?		0	1	2	3	4	
	Having flashbacks in which you found yourself reliving some terrible experience over and over?		0	1	2	3	4	
XIII.	Drinking at least 4 drinks of any kind of alcohol in a single day?		0	1	2	3	4	
	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?		0	1	2	3	4	
	Using any of the following medicines ON YOUR OWN (without a doctor's prescription), in large amounts, or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?		0	1	2	3	4	
	Anyone remarking on or expressed concern about your use of alcohol or drugs?		0	1	2	3	4	
	Having drug or alcohol use cause other problems in your life?		0	1	2	3	4	

XIV.	Feeling fat even when other people express concern that you are thin enough or too thin?		0	1	2	3	4	
	Eliminating foods or restricting your overall food intake?		0	1	2	3	4	
	Eating so much you make yourself feel sick?		0	1	2	3	4	
	Eating to comfort, soothe, reward, or punish yourself?		0	1	2	3	4	
	Feeling that your eating was excessive and/or not really normal?		0	1	2	3	4	
	Feeling out of control when eating?		0	1	2	3	4	
	Worrying all the time about food or weight issues?		0	1	2	3	4	
	Feeling depressed, ashamed, or disgusted after eating?		0	1	2	3	4	
	Vomiting, using laxatives or diuretics, or exercising excessively to try to make up for eating too much?		0	1	2	3	4	
	Please fill out the *Eating and Body Image Check Sheet* form if you have had any of these issues, past or present.							
	Other feelings or symptoms that we have not mentioned? Specify:		0	1	2	3	4	

Have any of these symptoms -- drinking, drug use, moods, anxiety, etc. – ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain. _____

_____

_____

Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain. _____

_____

_____

Has your health ever suffered as a result of any of these symptoms? If yes, please explain. _____

_____

_____

Have you ever received medication or treatment for any of these symptoms? If yes, please explain. ___

_____

_____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates. _____

_____

_____

In your own words, please identify the concern(s) that you want to address in counseling. Be as specific as you can. _____

_____

_____

_____

_____

_____

_____

Chrysalis
Center for Counseling and Eating Disorder Treatment

Client Name: _____ Date: _____

Weight History:

How tall are you? _____ Current Weight _____ Desired Weight _____
Lowest Weight _____ Date/age of this weight_____
Highest Weight _____ Date/age of this weight_____
How often do you weigh yourself? _____

Food History:

Restrictive Eating/Dieting (please check all that apply)

	Past	Current		Past	Current
skipping meals	_____	_____	fasting	_____	_____
reducing portions	_____	_____	reducing calories	_____	_____
restricting carbs	_____	_____	restricting fats	_____	_____
restricting protein	_____	_____	restricting dairy	_____	_____
chewing & spitting	_____	_____	throwing away food	_____	_____

Binging/Compulsive Eating (please check all that apply)

	Past	Current		Past	Current
eating sweets	_____	_____	eating a lot in a short period of time	_____	_____
eating carbs	_____	_____	feeling out of control when eating	_____	_____
eating dairy	_____	_____	eating until uncomfortably full	_____	_____
eating to soothe self	_____	_____	guilt/shame after eating	_____	_____
eating to punish self	_____	_____	eating for emotional reasons	_____	_____

Specify binge foods_____

Purging/Weight Control Measures:

Behaviors	Past	Current	# of times/pills per day	# of days per week
Vomiting	_____	_____	_____	_____
Diet Pills	_____	_____	_____	_____
Laxatives	_____	_____	_____	_____
Diuretics	_____	_____	_____	_____

	# of mins per day	# of days per week	Type & Duration
Current Exercise	_____	_____	_____
Past Exercise	_____	_____	_____

Substance Use: Which of the following substances do you use? Specify amount and frequency.

	Past	Current	Type, amount & frequency
Alcohol	_____	_____	_____
Drugs	_____	_____	_____
Cigarettes	_____	_____	_____
Caffeine	_____	_____	_____
Soda	_____	_____	_____

Possible contributors to eating and body image issues (check all that apply):

_____ teasing about appearance
_____ problems at school/work
_____ media influences
_____ family problems
_____ puberty
_____ medical reasons (illness/operation)
_____ depression
_____ death/loss
_____ divorce
_____ difficulty coping with stress
_____ relationship issues
_____ leaving home/separation
_____ difficult sexual experience
_____ prolonged period of dieting
_____ body image dissatisfaction
_____ problems with friends
_____ recommendation of weight loss by: (circle one)
parent significant other friend physician
_____ other (please explain)_____

Physical Symptoms:

Which of the following are you currently experiencing?

_____ loss of period
_____ irregular period
_____ nausea
_____ dizziness
_____ light-headedness
_____ fainting spells
_____ weakness
_____ fatigue
_____ lack of energy
_____ sleep problems
_____ acid reflux
_____ indigestion
_____ gas
_____ cramps
_____ bloating
_____ diarrhea
_____ sore throat
_____ swollen glands
_____ ulcers
_____ dental problems
_____ irritated gums
_____ chest pain
_____ irregular heartbeat
_____ shortness of breath
_____ frequent urination
_____ dehydration
_____ water retention
_____ excessive thirst
_____ brittle hair
_____ hair loss
_____ dry skin
_____ yellowish skin
_____ coldness
_____ muscle cramps
_____ muscle weakness
_____ loss of muscle
_____ tingling
_____ numbness
_____ swelling of ankles
_____ swelling of hands
_____ fractures
_____ injuries
_____ other: _____

Last physical exam: when, where & with whom? _____

Psychological Symptoms: Which of the following have you experienced?

_____ irritability
_____ depression
_____ mood swings
_____ mania/high mood
_____ guilt
_____ worthlessness
_____ hopelessness
_____ perfectionism
_____ obsessive thoughts
_____ following strict routines/rigid rules
_____ engaging in rituals
_____ difficulty making decisions
_____ impaired concentration
_____ memory problems
_____ phobias
_____ panic attacks
_____ avoidance of social situations
_____ fear of sex
_____ promiscuous sexual behavior
_____ risky sexual behaviors
_____ thoughts of suicide
_____ self-mutilation (cutting, burning, etc.)

Who knows about your eating disorder? _____

Other questions or concerns that have not been specifically addressed:_____

_____

_____

Chrysalis
Center for Counseling
and Eating Disorder Treatment

**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____

Birth Date: _____

Social Security Number: _____

Relationship to Policy Holder: _____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

* Please see reverse side for secondary insurance information and consenting signature.

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature