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. _____

_____

_____

_____

_____

_____

_____

Yale Food Addiction Scale

Gearhardt, Corbin, Brownell, 2009
Contact: ashley.gearhardt@yale.edu

Client Name: _____ Date: _____ Sex: M F

This survey asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as:

- Sweets like ice cream, chocolate, doughnuts, cookies, cake, candy, ice cream
- Starches like white bread, rolls, pasta, and rice
- Salty snacks like chips, pretzels, and crackers
- Fatty foods like steak, bacon, hamburgers, cheeseburgers, pizza, and French fries
- Sugary drinks like soda pop

When the following questions ask about "CERTAIN FOODS" please think of ANY food similar to those listed in the food group or ANY OTHER foods you have had a problem with in the past year.

IN THE PAST 12 MONTHS:	Never	Once a month	2-4 times a month	2-3 times a week	4 or more times a week or daily
1. I find that when I start eating certain foods, I end up eating much more than planned	0	1	2	3	4
2. I find myself continuing to consume certain foods even though I am no longer hungry	0	1	2	3	4
3. I eat to the point where I feel physically ill	0	1	2	3	4
4. Not eating certain types of food or cutting down on certain types of food is something I worry about	0	1	2	3	4
5. I spend a lot of time feeling sluggish or fatigued from overeating	0	1	2	3	4
6. I find myself constantly eating certain foods throughout the day	0	1	2	3	4
7. I find that when certain foods are not available, I will go out of my way to obtain them. For example, I will drive to the store to purchase certain foods even though I have other options available to me at home.	0	1	2	3	4
8. There have been times when I consumed certain foods so often or in such large quantities that I started to eat food instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.	0	1	2	3	4
9. There have been times when I consumed certain foods so often or in such large quantities that I spent time dealing with negative feelings from overeating instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.	0	1	2	3	4
10. There have been times when I avoided professional or social situations where certain foods were available, because I was afraid I would overeat.	0	1	2	3	4
11. There have been times when I avoided professional or social situations because I was not able to consume certain foods there.	0	1	2	3	4
12. I have had withdrawal symptoms such as agitation, anxiety, or other physical symptoms when I cut down or stopped eating certain foods. (Please do NOT include withdrawal symptoms caused by cutting down on caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)	0	1	2	3	4
13. I have consumed certain foods to prevent feelings of anxiety, agitation, or other physical symptoms that were developing. (Please do NOT include consumption of caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)	0	1	2	3	4
14. I have found that I have elevated desire for or urges to consume certain foods when I cut down or stop eating them.	0	1	2	3	4
15. My behavior with respect to food and eating causes significant distress.	0	1	2	3	4
16. I experience significant problems in my ability to function effectively (daily routine, job/school, social activities, family activities, health difficulties) because of food and eating.	0	1	2	3	4

Yale Food Addiction Scale

Gearhardt, Corbin, Brownell, 2009
Contact: ashley.gearhardt@yale.edu

Client Name: _____ Date: _____ Sex: M F

IN THE PAST 12 MONTHS:	NO	YES
17. My food consumption has caused significant psychological problems such as depression, anxiety, self-loathing, or guilt.	0	1
18. My food consumption has caused significant physical problems or made a physical problem worse.	0	1
19. I kept consuming the same types of food or the same amount of food even though I was having emotional and/or physical problems.	0	1
20. Over time, I have found that I need to eat more and more to get the feeling I want, such as reduced negative emotions or increased pleasure.	0	1
21. I have found that eating the same amount of food does not reduce my negative emotions or increase pleasurable feelings the way it used to.	0	1
22. I want to cut down or stop eating certain kinds of food.	0	1
23. I have tried to cut down or stop eating certain kinds of food.	0	1
24. I have been successful at cutting down or not eating these kinds of foods	0	1

25. How many times in the past year did you try to cut down or stop eating certain foods altogether?	1 time	2 times	3 times	4 times	5 or more times

26. Please circle ALL of the following foods you have problems with:

Ice cream	Chocolate	Apples	Doughnuts	Broccoli	Cookies	Cake	Candy
White Bread	Rolls	Lettuce	Pasta	Strawberries	Rice	Crackers	Chips
Pretzels	French Fries	Carrots	Steak	Bananas	Bacon	Hamburgers	Cheeseburgers
Pizza	Soda Pop	None of the above					

27. Please list any other foods that you have problems with that were not previously listed:

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? _____
When did you first have a problem with weight? (childhood, adolescence, pregnancy, etc.) _____

_____

What do you think are the main contributors to your weight? (i.e. genetics, poor food choices, lack of exercise, medications, etc.)?_____

_____

How has your weight been affecting you lately? _____

_____

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	_____	_____

Diet history (please list):

Name/type of diet plan:	How long did you follow this plan?	How much weight did you lose?

Emotional eating

Do you find that you frequently (more than 2x/week) eat in response to negative emotions? Y N
Do you find that you frequently (more than 2x/week) use food as a coping mechanism? Y N
Do you find that you frequently (more than 2x/week) use food to calm yourself? Y N
Do you feel that eating in response to stress or emotions contributes to your weight or makes it hard for you to lose weight? Y N

Night eating

Do you find that you're not hungry when you wake up in the morning? Y N
Do you think that the majority of your calories are eaten after dinner? Y N
Do you ever wake up in the middle of the night and eat? Y N
If so, what types of foods do you eat?_____

_____

Mindless eating

Which of the following do you do more than 2 times per week?

_____ eat while driving
_____ eat while at your computer or on your phone
_____ finish a portion of food and didn't realize you ate it
_____ eat in front of the TV
_____ eat in your bed
_____ eat standing up

Daily Intake:

How many meals or snacks do you eat in a typical day? _____
Do you tend to eat planned meals and snacks, or do you find that you eat continuously during the day or evening?_____

_____

Are your portion sizes typically small, medium, or large? Please give examples. _____

_____

Are there specific times/situations you are more likely to eat larger portions? _____

_____

How often do you drink caloric beverages like soda, juice, sweet tea, sports drinks, or energy drinks?

_____

How often do you eat fast food? _____ times per week or month (circle which applies)
How often do you eat at restaurants? _____ times per week or month (circle which applies)
How often do you eat take-out? _____ times per week or month (circle which applies)
How often do you eat dessert? _____ times per week or month (circle which applies)

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
_____ recommendation of weight loss by: (circle one)
parent significant other friend physician
_____ other (please explain)_____

_____divorce
_____ difficulty coping with stress
_____ relationship issues
_____ leaving home/separation
_____ difficult sexual experience
_____ prolonged period of dieting
_____ body image dissatisfaction
_____ problems with friends

Physical Symptoms/Medical Conditions:

Which of the following are you currently experiencing/have you been diagnosed with?

_____ loss of period
_____ irregular period
_____ nausea
_____ dizziness
_____ tingling
_____ numbness
_____ fatigue
_____ trouble sleeping
_____ gas
_____ cramps
_____ bloating
_____ diarrhea
_____ constipation

_____ ulcers
_____ chest pain
_____ irregular heartbeat
_____ shortness of breath
_____ frequent urination
_____ dehydration
_____ water retention
_____ excessive thirst
_____ swelling of ankles
_____ swelling of hands
_____ headaches/migraines
_____ excessive sweating
_____ PCOS

_____ infertility
_____ anemia
_____ acid reflux/GERD
_____ diabetes
_____ hypoglycemia
_____ hypothyroid
_____ high cholesterol
_____ hypertension
_____ joint pain
_____ cardiac issues
_____ sleep apnea
other: _____
_____

Last physical exam: when, where, and 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.)

Weight Loss Surgery Preparation:

How long have you been thinking about having weight loss surgery? _____

_____

Who knows about your decision to pursue weight loss surgery? _____

_____

Listed below are a few common reasons people want to have surgery. Please rate how important each one is to your desire to have this surgery? Circle your <u>most</u> important reason.

	Not at all	Slightly	Moderately	Considerably	Extremely	N/A
Increase mobility						
Increase energy						
Resume/adopt new activities						
Improve social life						
Enhance occupational functioning						
Improve health						
Prevent future health problems						
Increase life expectancy						
Decrease pain						
Feel better						
Improve appearance						
Improve self-esteem						
Improve sex life						
Improve relationship w/ significant other						
Practical reasons/Quality of life						
Other (describe):						

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