Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

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

RIGHTS & CONSENT TO TREATMENT

- ❑ You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ You have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- ❑ I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- ❑ You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- ❑ I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- ❑ I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- ❑ I understand that there is no guarantee that any particular outcome will result from treatment.
- ❑ I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians and nutritionists actively collaborate and consult about mutual cases, as well as share clinical notes.
- ❑ I understand that my therapist may consult and share clinical information with her supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. She may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- ❑ I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although any Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature _____ **Date** _____

Revised 02.23.2017
Date of NPP 05.25.2010

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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others under the circumstances described in our Notice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kaitlyn Patterson, MA, LPA, Privacy Officer, at kaitlyn.patterson@chrysaliscenter-nc.com or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Privacy Officer at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter to the Privacy Officer). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understand its content, and agree to its stipulations.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Relationship to Client (if guardian or representative):_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).

□ I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

□ ***Client Refuses to Acknowledge Receipt**:*

Signature of authorized representative of this office or practice: _____

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OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, complete, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS:
All office visits are by appointment and scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late, you will be asked to reschedule your appointment, which will result in a *late cancellation* charge.

PAYMENT:
Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a check is returned, you will be asked to arrange another method of payment.*

All clients are required to place a credit card on file in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment taken, credits and debits will be applied to the card immediately. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

Name (as it appears on the card): _____

Card Number: _____

Phone number of credit card holder: _____ Billing Zip code: _____

Expiration Date: _____ CVV/CVC: _____

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $60 for the appointment. Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE:
As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. *It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.*

Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file.

Please note: treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier

may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and may also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Please note: No provider at Chrysalis will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____ I have read, understand, and agree to the above policies.

_____ I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

_____ I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

_____ I have been offered a copy of these policies to take with me if I desire.

_____ I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements at time of service

_____ I have discussed these policies and addressed concerns and questions with the administrative staff if needed. Initial and date by administrative staff if questions were addressed: _____

_____ _____

Signature of Client Date

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____ _____

Signature of parent or Legal Guardian Date

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**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.*

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

Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, and the following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately, and you will be charged the full rate for services already rendered.

_____ Please initial if you do not want to use your insurance benefits; you will be charged the self-pay rate for services.

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: _____

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

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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. ***If you do not complete these forms in their entirety prior to your first appointment, you will not be able to see any provider at Chrysalis Center.***

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: _____ Gender: _____

Ethnic Group: _____ Religious Preference: _____

Relationship Status: _____Single _____Cohabitating _____Married
_____Separated _____Divorced _____ Widowed

Emergency Contact: _____ Telephone: (_____) _____

Parent/Guardian Name (if relevant): _____

Address: _____ Telephone: (_____) _____

Referral/Clinical Information:

How did you find out about our services? _____

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
_____ Intensive Outpatient Program

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

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:

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

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)

Health Information:

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

_____

_____

Allergies/Adverse Reactions to Treatment:_____

_____

Primary Care Physician Name: _____

Date of Last Physical: _____ Telephone: (____) _____

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

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?

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

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.

Portions of this form have been adapted from the American Psychological Association Diagnostic and Statistical Manuel 5's Cross Cutting Symptoms Measures for Adults and Adolescents and/or the Boston Interview for Gastric Bypass as appropriate.

I**nstructions:** 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 problems?		0	1	2	3	4	

	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. _____

_____

_____

_____

_____

_____

_____

EATING AND BODY IMAGE CHECK SHEET

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		

Have you ever deliberately lost so much weight that people expressed concern? Y N

Have you ever been afraid of getting fat even when other people said you were thin enough or too thin? Y N

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			eating until you felt sick		
eating to punish self			guilt/shame after eating		
depression after eating			eating for emotional reasons		

Specify binge foods _____

Have you ever felt that your eating was excessive and/or not really normal? Y N

Purging/Weight Control Measures:

Have you ever vomited, used laxatives or diuretics, or exercised excessively to try to make up for eating too much? Y N

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			

EATING AND BODY IMAGE CHECK SHEET

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:

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:_____

_____

_____