
# EDRC
# INITIAL PATIENT ASSESSMENT

Updated: July 19, 2012

# Department of Psychiatry
# Eating Disorder Recovery Center
# Initial Assessment

## PATIENT INFORMATION

| NAME IN FULL | ☐ F ☐ M | AGE | DATE OF BIRTH | TODAY'S DATE |
|---|---|---|---|---|
| | | | | |

| ADDRESS | | | |
|---|---|---|---|
| | | | |
| CITY | COUNTY | STATE | ZIP CODE |
| | | | |
| HOME TELEPHONE NUMBER | WORK TELEPHONE NUMBER | CELL NUMBER | MARITAL STATUS |
| | | | |
| OCCUPATION | EMPLOYER | | |
| | | | |
| REASON FOR APPOINTMENT | REFERRED BY/HOW DID YOU HEAR ABOUT US | | |
| | | | |

## COMPLETE IF PATIENT IS A MINOR

| MOTHER'S NAME | FATHER'S NAME |
|---|---|
| | |
| CUSTODY<br>☐Both Parents ☐Mother ☐Father ☐Other _____ | LIVES WITH<br>☐Both Parents ☐Mother ☐Father ☐Other _____ |
| PARENT'S/CONTACT'S TELEPHONE NUMBER | TELEPHONE NUMBER FOR |
| | |

## EMERGENCY CONTACT

| NAME | RELATIONSHIP TO PATIENT | HOME TELEPHONE NUMBER | WORK TELEPHONE NUMBER |
|---|---|---|---|
| | | | |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | | |

## CONTACTS

| PRIMARY CARE PHYSICIAN | SPECIALTY | LAST APPOINTMENT | HOW LONG HAVE THEY TREATED YOU? |
|---|---|---|---|
| | | | |
| CITY | STATE | PHONE NUMBER | |
| | | | |

| PSYCHIATRIST | | LAST APPOINTMENT | HOW LONG HAVE THEY TREATED YOU? |
|---|---|---|---|
| | | | |
| CITY | STATE | PHONE NUMBER | |
| | | | |

| THERAPIST | | LAST APPOINTMENT | HOW LONG HAVE THEY TREATED YOU? |
|---|---|---|---|
| | | | |
| CITY | STATE | PHONE NUMBER | |
| | | | |
| HOW OFTEN DO YOU MEET? | DO YOU FIND IT HELPFUL? | | |
| | | | |
| IF NOT CURRENTLY IN THERAPY, HAVE YOU BEEN IN THE PAST? | IF SO, WAS IT HELPFUL? | | |
| | | | |

| NUTRITION THERAPIST | | LAST APPOINTMENT | HOW LONG HAVE THEY TREATED YOU? |
|---|---|---|---|
| | | | |
| CITY | STATE | PHONE NUMBER | |
| | | | |
| HOW OFTEN DO YOU MEET? | DO YOU FIND IT HELPFUL? | | |
| | | | |
| IF NOT CURRENTLY IN THERAPY, HAVE YOU BEEN IN THE PAST? | IF SO, WAS IT HELPFUL? | | |
| | | | |

# Medical History

| **MEDICAL PROBLEMS for which you are being treated**: | | |
|---|---|---|
| PROBLEM | DOCTOR | HOW TREATED |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

| **SURGERIES you have had:** | |
|---|---|
| SURGERY | WHEN |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

| **MEDICATIONS and over-the-counter pills you are taking currently:** | | |
|---|---|---|
| NAME OF MEDICATION | DOSAGE | HOW OFTEN TAKEN |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

| **ALLERGIES:** | |
|---|---|
| **Are you allergic to any medications?** ☐ Yes ☐ No If so please list: | |
| **DRUG** | **PROBLEM** |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**Do you have any food allergies?** ☐ **Yes** ☐ **No** **If so please list:**

# Psychiatric Medication History (check meds used in past):

**Antidepressants**

Anafranil (clomipramine) ☐ Yes
Celexa (citalopram) ☐ Yes
Cymbalta (duloxetine) ☐ Yes
Desyrel (trazodone) ☐ Yes
Effexor XR (venlafaxine) ☐ Yes
Elavil (amitriptyline) ☐ Yes
Lexapro (escitalopram) ☐ Yes
Luvox (fluvoxamine) ☐ Yes
Nardil (phenelzine) ☐ Yes
Norpramin (desipramine) ☐ Yes
Pamelor (nortriptyline) ☐ Yes
Parnate (tranylcypromine) ☐ Yes
Paxil (paroxetine) ☐ Yes
Prozac (fluoxatine) ☐ Yes
Remeron (mirtazapine) ☐ Yes
Sarafem (fluoxetine) ☐ Yes
Serzone (nefazodone) ☐ Yes
Symbyax (fluoxetine/olanzapine) ☐ Yes
Tofranil (imipramine) ☐ Yes
Wellbutrin (bupropion) ☐ Yes
Zoloft (sertraline) ☐ Yes
Other: _____
Other: _____
Other: _____

**Addiction Medications**

Suboxone/ Subutex ☐ Yes
Campral/ Naltrexone/ Vivitrol ☐ Yes
Methadone ☐ Yes
Other: _____

**Other Medications**

Other: _____
Other: _____
Other: _____
Other: _____

**Anxiolytics/Tranquilizers**

Ambien (zolpidem) ☐ Yes
Ativan (lorazepam) ☐ Yes
Bromam (bromazepam) ☐ Yes
BuSpar (buspirone) ☐ Yes
Halcion (triazolam) ☐ Yes
Klonopin (clonazepam) ☐ Yes
Librium (chlordiazepoxide) ☐ Yes
Lunesta (eszopiclone) ☐ Yes
Restoril (temazepam) ☐ Yes
Rohypnol (flunitrazepam) ☐ Yes
Tranxene (clorazepate) ☐ Yes
Valium (diazepam) ☐ Yes
Xanax (aprazolam) ☐ Yes
Other: _____

**Mood Stabilizers**

Abilify (ariprazole) ☐ Yes
Depakote (valproate) ☐ Yes
Geodon (ziprasidone) ☐ Yes
Lamictal (lamotrigine) ☐ Yes
Lithium ☐ Yes
Neurontin (gabapentin) ☐ Yes
Risperdal (risperidone) ☐ Yes
Seroquel (quetiapine) ☐ Yes
Tegretol (carbamazepine) ☐ Yes
Topamax (topiramate) ☐ Yes
Tripleptal (oxcarbazepine) ☐ Yes
Zyprexa (olanzapine) ☐ Yes

**Stimulants/ADHD**

Adderall ☐ Yes
Concerta (methylphenidate) ☐ Yes
Dexedrine (dextroamphetamine) ☐ Yes
Focalin (dexmethylphenidate) ☐ Yes
Ritalin ☐ Yes
Strattera (atomoxetine) ☐ Yes

# Current Medical Concerns

Check all that apply

**Cardiovascular**

| | |
|---|---|
| | Heart problems Requiring medication? |
| | Chest pains |
| | Racing heart/skipping |
| | High blood pressure Requiring medication? |
| | Chest tightness |
| | Shortness of breath |
| | High cholesterol Requiring medication? |
| | High triglycerides Requiring medication? |
| | Feel tired all the time |

**Diabetes**

| | |
|---|---|
| | Diabetes - Type I or II Requiring medication? |
| | Pre-diabetic Elevated blood sugar? |
| | Gestational diabetes Age of Diagnosis? |
| | Hypoglycemia (low blood sugar |

**Thyroid Problems**

| | |
|---|---|
| | Hypothyroidism |
| | Hyperthyroidism |

**Gastrointestinal**

| | |
|---|---|
| | Gallbladder problems Removed? |
| | Stomach ulcers Requiring medication? |
| | Heartburn Daily? Nocturnal? |
| | Regurgitation Requiring medication? |
| | Diarrhea Requiring medication? |
| | Constipation Requiring medication? |

**Respiratory**

| | |
|---|---|
| | Asthma Last attack? |
| | Bronchitis # of times in past 2 years Is it recurring? |
| | Pneumonia # of times in past 2 years |
| | Blood clots in lungs |
| | Smoker Starting age? When did you stop? |
| | Smokeless tobacco |
| | Snore |
| | Wake up gasping or with a smothered feeling |

**Musculoskeletal**

| Location | Mild | Moderate | Severe |
|---|---|---|---|
| Hip pain | | | |
| Knee pain | | | |
| Ankle pain | | | |
| Feet pain | | | |
| Back pain | | | |
| Neck pain | | | |
| Arthritis | | | |

**Females Only - Menstrual History**

**Are you currently menstruating?** ☐ Yes ☐ No ☐ Have never menstruated

**Date of last menstrual cycle** _____**Average weight fluctuation during menstrual cycle** _____

**As you lose weight do you cycles become irregular?** ☐ Yes ☐ No

**Age began:** _____ **Approximate weight at time of first menstruation:** _____

**Approximate height when began:** _____

**Are you taking birth control pills/patches/injections?** ☐ Yes ☐ No

**Do you have PMS?** ☐ Yes ☐ No If yes, please describe _____

# Family and Social History

**Have you ever experience any of the following?**

**FAMILY:**

- Death of a parent ☐
- Death of other loved one or close friend ☐
- Life threatening illness in immediate family ☐
- Separation from a parent for > a month ☐
- Parent's separation/divorce ☐
- Loss of home through natural disaster ☐
- Family financial problems ☐
- Parent with substance abuse problem ☐
- Significant conflict with parents ☐
- Foster care ☐

**ABUSE/TRAUMA:**

- Physical abuse ☐
- Sexual abuse ☐
- Verbal/Emotional abuse ☐
- Neglect ☐
- Rape ☐
- Other traumatic event ☐

If yes, please explain: _____

_____

**SOCIAL (in comparison to your peers did you feel):**

- Isolation ☐
- Excessively picked on or bullied ☐
- Excessive shyness ☐
- Poor peer relationships ☐
- Illegal behavior ☐

**SELF:**

- Delayed speech ☐
- Delayed motor development ☐
- Chronic illness ☐
- Obesity ☐

**SCHOOL:**

- Academic problems ☐
- Behavior problems ☐
- Learning problems ☐
- School failure/dropout ☐

Are you currently a student?

☐ Yes ☐ No

Highest grade level you completed ___

What grades did you make in school?

**What is your occupation/career? How long have you worked in this capacity?** _____

_____

**What, if any, legal problems have you had?** _____

_____

**What stresses are in your life now?** _____

_____

**What is your current living situation?** _____

_____

**Describe your social support system:** _____

_____

**Describe how your eating disorder is affecting your life:** _____

_____

**Are you currently married?** ☐ Yes ☐ No How many times have you been married? _____

**How many children do you have?** _____ Their ages: _____

**For women:** How many times have you been pregnant? _____ How did you deliver? _____

# Psychological History

| PSYCHIATRIC or SUBSTANCE ABUSE treatment history: | | |
|---|---|---|
| **INPATIENT - WHERE** | **DATES** | **REASON** |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

| **OUTPATIENT – WHO TREATED** (please include counseling/therapy) | **DATES** | **REASON** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**Have you ever attended AA/ NA/ Alanon/ Alateen or OA meetings?** ☐ Yes ☐ No

**Have you been treated or diagnosed with any of the following:**

**Depression**
For the past few weeks have you felt:
(circle or check any that apply)
- Down or sad?
- Had trouble sleeping?
- Problems concentrating?
- Felt restless?
- Felt worthless or guilty?
- Had thoughts of hurting yourself?
- Had thought of killing yourself?

**Bipolar Disorder**
For the past few weeks have you felt:
(circle or check any that apply)
- Distractibility
- Irritability
- Felt very powerful or entitled
- Engaged in increased risk taking behavior (sexual promiscuity, spending money, dangerous activities)
- Spoke rapidly
- Felt as though your mind was racing
- Didn't' need to sleep for several days

**Anxiety**
Have you ever been diagnosed with an anxiety disorder?
Check all that apply
- Obsessive Compulsive Disorder (OCD)
- Generalized Anxiety Disorder (GAD)
- Social Anxiety/ Social Phobia
- Panic Disorder
- Post-Traumatic Stress Disorder (PTSD)

I would you describe yourself as an anxious person?
☐ Yes ☐ No
I worry a lot about everyday things?
☐ Yes ☐ No
I have obsessive thoughts related to anything specific
☐ Yes ☐ No
I have any ritualistic activities (Checking locks repeatedly, washing hands repeatedly?) ☐ Yes ☐ No

**Have you ever had any Suicide Attempts?** ☐ **Yes** ☐ **No**

Have you ever heard voices when no one was around or seen things others have not seen? ☐ Yes ☐ No

Do you feel you have special powers or abilities? ☐ Yes ☐ No

Do you feel that others are following you, stealing from you or trying to hurt you? ☐ Yes ☐ No

Do you feel others can control your thoughts or actions? ☐ Yes ☐ No

| **Please answer the following:** | **Yes** | **No** |
|---|---|---|
| How many drinks do you need to feel a buzz/"high"? _____ | | |
| Are you or others concerned with how much you drink? | ☐ | ☐ |
| Do you need a drink in the morning? | ☐ | ☐ |
| Do you have periods of time you don't remember associated with your drinking? | ☐ | ☐ |
| Have you ever blacked out from drinking? | ☐ | ☐ |
| Have you tried to cut down your drinking? | ☐ | ☐ |

| Please check which substances you have used in your lifetime: | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Current** | **Past** | **Date of last use:** | | **Current** | **Past** | **Date of last use:** |
| Alcohol | ☐ | ☐ | | Amphetamines | ☐ | ☐ | |
| Tobacco | ☐ | ☐ | | Stimulants | ☐ | ☐ | |
| Marijuana | ☐ | ☐ | | Tranquilizers | ☐ | ☐ | |
| Cocaine | ☐ | ☐ | | Opiates/pain pills | ☐ | ☐ | |
| Crack | ☐ | ☐ | | Soma/muscle relaxants | ☐ | ☐ | |
| Heroin | ☐ | ☐ | | Ultram/tramadol | ☐ | ☐ | |
| Ecstasy | ☐ | ☐ | | Stadol | ☐ | ☐ | |
| LSD | ☐ | ☐ | | Codeine | ☐ | ☐ | |
| Mushrooms | ☐ | ☐ | | Propoxyphene/Darvon | ☐ | ☐ | |
| GHB | ☐ | ☐ | | Sleeping pills | ☐ | ☐ | |
| PCP | ☐ | ☐ | | Inhalants | ☐ | ☐ | |
| Ketamine (special "K") | ☐ | ☐ | | Nitrous oxide | ☐ | ☐ | |
| Rohypnol | ☐ | ☐ | | IV drugs | ☐ | ☐ | |

# Please Fill Out To The Best Of Your Knowledge

Do you weigh yourself? ☐ Yes ☐ No

How often? _____

How many calories do you need to maintain your current weight? _____

How many calories do you need to maintain your ideal weight? _____

How tall are you? _____ft _____in

**Current** weight? _____lbs

**Desired** weight? _____lbs

How many calories do you eat daily? _____

For Office Use Only
BMI: _____
HAMWI: _____

**Highest** weight? _____lbs

When? _____

What contributed to this?

_____

_____

For Office Use Only
BMI: _____

**Lowest** weight? _____lbs

When? _____

What contributed to this?

_____

_____

For Office Use Only
BMI: _____

**Has anyone ever told you need to lose weight?** ☐ Yes ☐ No
If yes, who and when? _____

**Has anyone ever told you need to gain weight?** ☐ Yes ☐ No
If yes, who and when? _____

**Check to indicate which of your family members:**

**Are "overweight":** ☐ Yes ☐ No
If yes, who and when? _____

**Try to eat healthy:** ☐ Yes ☐ No
If yes, who and when? _____

**Try to control weight:** ☐ Yes ☐ No
If yes, who and when? _____

**Have an eating disorder:** ☐ Yes ☐ No
If yes, who and when? _____

**What is your family's attitude about health/ weight?**_____

# EATING PATTERNS

**How hungry do you let yourself get:** (not at all) 0---1---2---3---4---5---6---7---8---9---10(so much you get cramps)

**Describe what hunger feels like to you** _____

_____

**Describe what fullness feels like to you** _____

_____

**How do you know when to quit eating** _____

_____

**Check any of the following that describe your eating patterns recently:**

| | | |
|---|---|---|
| ☐ Eat 1 meal a day | ☐ Eat when I get hungry | ☐ Induce vomiting |
| ☐ Eat 2 meals a day | ☐ Eat when not hungry | ☐ Use laxatives |
| ☐ Eat 3 meals a day | ☐ Eat in response to boredom | ☐ Use diuretics |
| ☐ Eat less than others | ☐ Eat in response to stress | ☐ Use Ipecac syrup |
| ☐ Eat more than others | ☐ Eat in response to depression | ☐ Eat in secret |
| ☐ Eat "normally" | ☐ Eat in response to anxiety | ☐ Hide food |
| ☐ Eat snacks between some meals | ☐ Eat in response to loneliness | ☐ Binge eat |
| ☐ Eat snacks between all meals | ☐ Eat in response to habit | ☐ Feel guilty after eating |
| ☐ Overeat most of the day | ☐ Eat in response to anger | ☐ Keep a food journal |
| ☐ Overeat some of the day | ☐ Eat in response to self-reward | ☐ Eat slower than others |
| ☐ Restrict amount of food intake | ☐ Eat in response to PMS | ☐ Eat faster than others |
| ☐ Restrict type of food intake | ☐ Eat in response to comfort | ☐ Eat standing up |
| ☐ Eat more than intended in one sitting | ☐ Eat in response to habit | ☐ Eat with others |
| ☐ Feel out of control when eating | ☐ Eat in response to external cues | ☐ Eat alone |

| **Do you have foods that you do NOT eat/drink?** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Red meat | ☐ | Dairy | ☐ | Fried foods | ☐ | Water | ☐ |
| Poultry | ☐ | Eggs | ☐ | Sugar products | ☐ | Regular soda | ☐ |
| Pork | ☐ | Fruit | ☐ | Carbohydrates | ☐ | Diet soda | ☐ |
| Fish | ☐ | Vegetables | ☐ | (pasta, rice, and bread) | | Juices | ☐ |
| Other: _____ | | Other: _____ | | Other: _____ | | Other: _____ | |

| **Which food could you NOT do without?** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Candy | ☐ | Doughnuts | ☐ | Meat | ☐ | Fruit | ☐ |
| Chocolate | ☐ | Cheese | ☐ | Eggs | ☐ | Vegetables | ☐ |
| Cookies | ☐ | Chips | ☐ | Pizza | ☐ | Soda | ☐ |
| Pie/Cake | ☐ | Rice | ☐ | Bread | ☐ | Alcohol | ☐ |
| Ice Cream | ☐ | Pasta | ☐ | Fried Food | ☐ | Juice | ☐ |
| Other: _____ | | Other: _____ | | Other: _____ | | Other: _____ | |

**What are your favorite foods?** _____

**What beverages do you drink?**

| | | | |
|---|---|---|---|
| ____water | ____whole milk | ____2% milk | ____1% milk |
| ____skim milk | ____regular soda | ____diet soda | ____regular coffee |
| ____decaf coffee | ____regular tea | ____decaf tea | ____juice |
| ____sweet tea | ____unsweetened tea | Others: _____ | |

**Number of fast food visits per week:** _____

**Do you eat uncontrollably at times?** ☐ Yes ☐ No If yes, age(s): _____

If yes, describe? _____

**Have you ever been diagnosed with an eating disorder?** ☐ Yes ☐ No

If yes, what and when? _____

# Dieting History

**Have you ever tried to control your weight?** ☐ Yes ☐ No

**If yes, age at first attempt**: ____ years **Your height at that time**: _____ **Your weight at that time**: _____

**Why did you go on the diet?** _____

_____

| **Which diets have you tried:** | | | | | |
|---|---|---|---|---|---|
| Weight Watchers | ☐ | Food Pyramid | ☐ | Beverly Hills diet | ☐ |
| Nutri/System | ☐ | Diabetic diet | ☐ | Scarsdale Diet | ☐ |
| Jenny Craig | ☐ | Liquid Diet | ☐ | Hollywood 48 hour diet | ☐ |
| LA Weight Loss | ☐ | Optifast | ☐ | Celebrity diet | ☐ |
| Richard Simmons | ☐ | Body For Life | ☐ | The Grapefruit diet | ☐ |
| Slimfast | ☐ | Fit For Life | ☐ | Cabbage soup diet | ☐ |
| Metabolife | ☐ | Medifast | ☐ | Mediterranean diet | ☐ |
| Atkins | ☐ | Mayo Clinic diet | ☐ | Subway diet | ☐ |
| HCG Diet | ☐ | Pritkin diet | ☐ | Fasting | ☐ |
| The Zone | ☐ | Raw diet | ☐ | Caveman diet | ☐ |
| South Beach | ☐ | Blood Test diet | ☐ | Low Calorie | ☐ |
| Low Carb diet | ☐ | Negative Calorie diet | ☐ | how many calories a day _____ | |
| Sugar Busters diet | ☐ | Cider Vinegar diet | ☐ | Other diets: | |

**What has been your most successful diet?** _____

**Why do you suppose this was the case?** _____

| **Which diet pills have you tried:** | | | | | |
|---|---|---|---|---|---|
| Fen-phen | ☐ | Meridia (sibutramine) | ☐ | Phenylpropanolamine (PPA) | ☐ |
| Dex-fen-phen | ☐ | Xenical (orlistat) | ☐ | Chromium Picolinate | ☐ |
| Redux (dexfenfluramine) | ☐ | Stimulants/Amphetamines | ☐ | Pyruvate | ☐ |
| Fastin (phentermine) | ☐ | (eg. Ritalin, Adderall) | | Dexatrim | ☐ |
| Adipex | ☐ | Dexedrine | ☐ | Acutrim | ☐ |
| Ionamin | ☐ | Ephedrine | ☐ | HCG | ☐ |
| Oby-trim | ☐ | Ephedra | ☐ | Diuretics/Water Pills | ☐ |
| Pondimin (fenfluramine ) | ☐ | Ma Huang | ☐ | Diet Teas | ☐ |
| Tenuate (diethylpropion) | ☐ | Caffeine | ☐ | Metabolife | ☐ |
| Dospan | ☐ | Gurarana | ☐ | Xenadrine | ☐ |
| Sanorex (mazindol) | ☐ | Bontril (phendimetrazine) | ☐ | Chitosan | ☐ |
| Mazanor | ☐ | Plegine | ☐ | Herbalife diet pills | ☐ |
| Didrex | ☐ | Prelu-2 | ☐ | Thyroid medication | ☐ |
| Wellbutrin (bupropion) | ☐ | X-Trozine | ☐ | Other:_____ | |

**Activity/Exercise History**

| **What is your regular activity level?** | | |
|---|---|---|
| **Minimally active** | (very sedentary, rarely leave house) | ☐ |
| **Somewhat active** | (light housework, gardening, walking on errands or while working) | ☐ |
| **Moderately active** | (exercise 1-3 times a week, walking for exercise) | ☐ |
| **Very active** | (exercise 3 or more times a week, e.g. aerobics, running, swimming, weight training, cycling) | ☐ |
| **Extremely active** | (daily vigorous exercise) | ☐ |

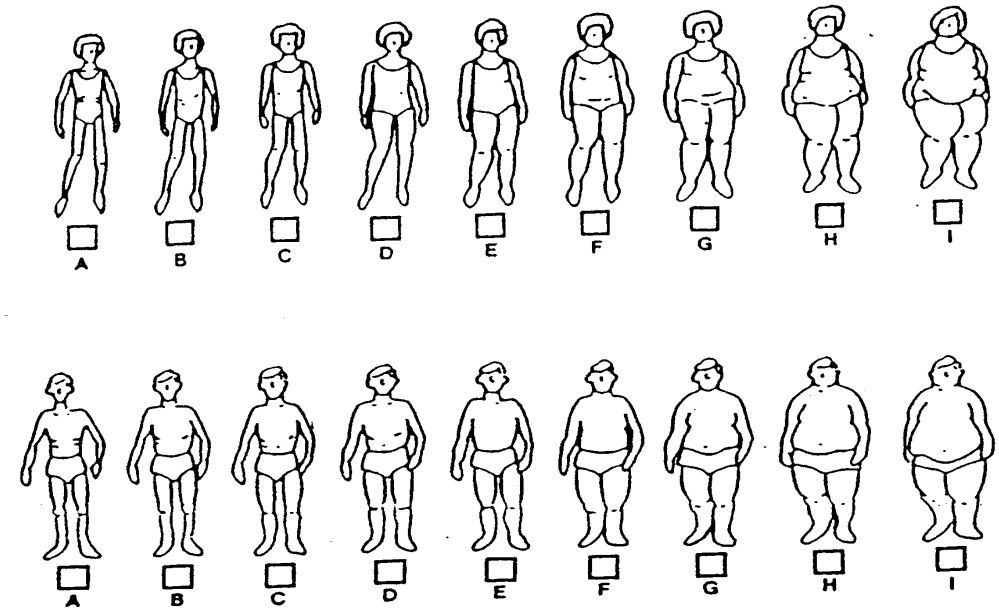
**Do you have any physical conditions that limit your ability/safety to exercise?** ☐ **Yes** ☐ **No**
**If yes, describe**: _____

**What is your favorite activity?** _____

**What is your favorite exercise?** _____

**How many days a week do you exercise? ___ How many times a day? ___ How many hours per day? ___**

**Check the figure you think you look like Now:**




**Check the figure you would most like to look like in the Future:**