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 ☐Both Parents ☐Mother ☐Father ☐Other _____	LIVES WITH ☐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)	☐

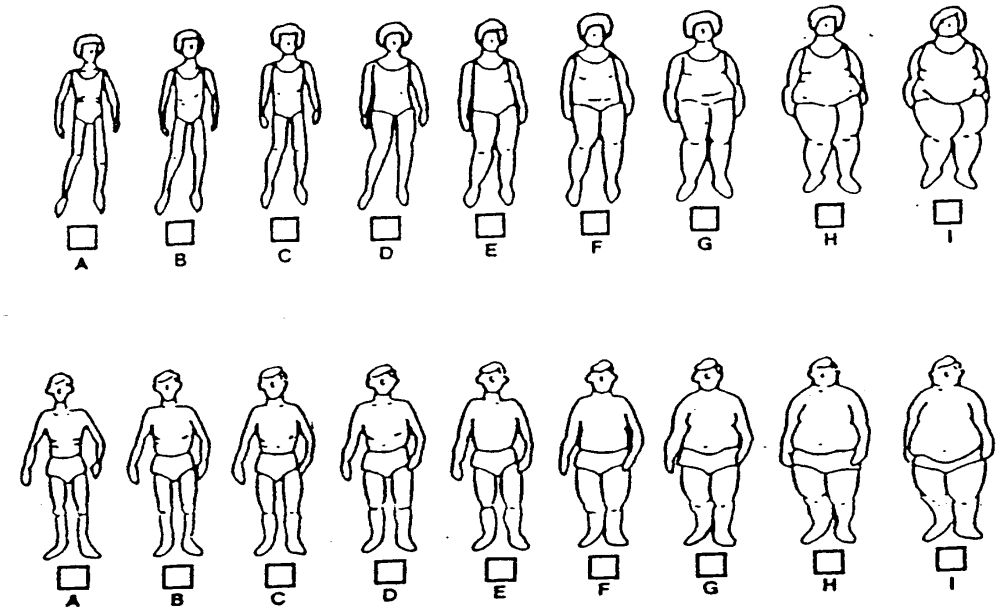
Do you have any physical conditions that limit your ability/safety to exercise? ☐ **Yes** ☐ **No**
If yes, describe: _____

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: