The Lotus Collaborative
Eating Disorder Recovery Center
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Confidential Personal Health Questionnaire

This information is confidential and will not be shared without your written permission. The purpose of the questionnaire is to help us understand you and develop a treatment plan tailored to your unique needs. Please answer questions to the extent you feel comfortable. When answering, please indicate if this is a current area of concern for you and provide relevant information to help us understand your concerns. ***This form is not meant as an intervention for suicidal or homicidal thoughts. If you are a danger to yourself or others, call 911 or go to your nearest Emergency Room.***

Name: **Date of Birth:** **Age:**

Address:

Email:
Okay to email you? yes no

Cell Phone:
Okay to leave a message? yes no

Home Phone:
Okay to leave a message? yes no

Name of Referral Source: (*Please indicate how you heard of our services (i.e. internet site, word of mouth, therapist)*

Phone #: **Okay to contact?** yes no

Demographic Information

What gender do you identify as?

What pronoun do you use?

What ethnicity do you identify as?

What sexual orientation do you identify as?

Do you identify as having a disability?

Are there any other cultural factors that you would like us to be aware of?

Financial Information

If you haven't already, please provide a current credit card to reserve your appointment time(s). You will only be charged if you do not provide a 24-hr cancellation notice or show for your appointment.

Name on card:
Card type and #:
Security code:
Billing zip code:

Are you requesting financial accommodation?

If you are requesting sliding scale or a treatment scholarship, please provide average monthly income and relevant documentation.

Current Professional Team

*Please list other professionals that you **currently** or **most recently** worked with.*

Name of Individual Therapist:
Phone # **Okay to contact?** yes no
What type of psychological concerns did you address and were you satisfied with the experience and outcome?

Name of Dietitian:
Phone # **Okay to contact?** yes no
What type of nutritional or weight concerns did you address and were you satisfied with the experience and outcome? Elaborate on meal plan, exchanges, calories, weight goal.

Name of Physician:
Phone # **Okay to contact?** yes no
Please indicate any medical diagnoses you've been given. When was your last physical?

Name of Psychiatrist:
Phone # **Okay to contact?** yes no

What psychological diagnoses have you been given? (Ex: Major Depressive Disorder, Generalized Anxiety Disorder, PTSD, OCD, Bulimia Nervosa)

Please list your current and past medication:

Medication	Dosage	Purpose	Past or Current

Name of Other Professional(s):
Phone # **Okay to contact?** yes no
What type of concerns did you address and were you satisfied with the outcome?

Past Treatment Centers

Treatment Center Name	**Level of Care** (Inpatient, Res, PHP, IOP)	**Purpose** (ED, Mood, Trauma, SI, etc.)	**Dates of Stay** Month/Year - Month/Year	**Reason for Discharge** (Insurance dropped, Graduation, Against Medical Advice, Etc.)

Eating Disorder Information

At what age did you first become aware of negative thoughts towards food, weight and body image?

At what age did you start having eating disorder behaviors and what were the behaviors?

Please describe a brief history of your eating disorder:

Please indicate what eating disorder behaviors your are *currently* experiencing:

Binge eating: *eating large amounts of food rapidly in a brief time period*

Do you engage in this: never infrequent monthly weekly daily

Compulsive eating: *eating large amounts of food over an extended period (i.e. throughout the day) instead of all at once*

Do you engage in this: never infrequent monthly weekly daily

Purging: *ridding the body of unwanted food through artificial means (i.e. vomiting, exercise or laxatives)*

Do you engage in this: never infrequent monthly weekly daily

Restricting: *not eating food or purposefully reducing food intake*

Do you engage in this: never infrequent monthly weekly daily

Other:

Please list what you ate, quantities and times you ate in the last 24 hours:

Using the table below, please describe your physical activity:

Activity	**Type and Intensity (low/moderate/high)**	**# days per week**	**Duration (minutes)**
Stretching/Yoga			
Cardio/Aerobics (walking/ jogging/biking/interval training)			
Strength Training (weight lifting/pilates/calisthenics)			
Sports or Leisure			
Other			

How does your eating change if you take a day off from physical activity?

Do you have any injuries?

For athletes: Do you train more than is recommended by your coaches? If so, please describe:

<u>Mental Health Information</u>

What are current mood, anxiety, or trauma-related symptoms that cause you distress?

How are you functioning in your current roles (i.e. student, parent, employee, partner)? Are you able to fulfill commitments at work, school, and in your personal life?

What substances do you currently use (i.e caffeine, alcohol, nicotine, drugs)? Please specify what, how often, and the amount for each.

Have you ever struggled controlling your substance use or experienced adverse consequences because of your use? (Examples: DUI/DWI, arrest, fired, blacked out, attended rehab, fought with loved ones or strangers)

Suicidal Thoughts

(Note: This assessment is not intended to be a crisis intervention document. If you are currently unable to keep yourself safe, please call 9-1-1 or go to the nearest emergency room of your choice.)

Have you ever struggled with thoughts or actions related to not wanting to be alive? If so, please describe these briefly, including the ages at which you experienced these:

Additionally, please describe any interventions and/or treatment you have received to address these symptoms:

Self-Harm

If you have struggled with self-harm, please describe the age you first experienced this, how frequently it occurs, and what type of self-harm you engage in.

Additionally, please describe any interventions and/or treatment you received to address this.

If you feel comfortable, please circle and provide ages if you have experienced any of the following types of abuse/trauma: emotional verbal sexual physical

What is your current living situation?

Do you currently provide care for dependant others? (Examples: children, ages, individuals with special needs, elderly)

Please circle if you are currently: employed unemployed a student on medical leave

Are there any additional stressors in your life? (Examples: financial, romantic, social, housing, occupational).

Medical Health Information

Does your primary care physician know that you have an eating disorder?

If applicable, when was your last menstruation cycle?

If applicable, have you ever been pregnant or are you currently pregnant?

Please circle any of the health problems you have that may have been caused by your eating disorder and indicate the frequency. Please <u>also</u> indicate if you are currently ("now") experiencing them.

Abnormal Labs/Bloodwork	now	often	sometimes	rarely	never
Fainting	now	often	sometimes	rarely	never
Dizziness	now	often	sometimes	rarely	never
Irregular or Low Heart Rate	now	often	sometimes	rarely	never
Accelerated Heart Rate	now	often	sometimes	rarely	never
Abnormal EKG/ECG	now	often	sometimes	rarely	never
Dental Issues	now	often	sometimes	rarely	never
Significant weight gain/loss	now	often	sometimes	rarely	never
Nausea	now	often	sometimes	rarely	never
Stomach Pain	now	often	sometimes	rarely	never
Gas	now	often	sometimes	rarely	never
Bloating	now	often	sometimes	rarely	never
Constipation	now	often	sometimes	rarely	never
Diarrhea	now	often	sometimes	rarely	never
Acid Reflux/Heartburn	now	often	sometimes	rarely	never
Abnormal Hair Loss/Growth	now	often	sometimes	rarely	never
Irregular Menstruation	now	often	sometimes	rarely	never
Amenorrhea (lack of menstruation)	now		in the past		never

Please indicate any other medical concerns or conditions that currently impact you:

<u>Motivation</u>

What is your motivation for treatment?

Why are you seeking treatment now?

Are you aware of any barriers to being in treatment for a minimum of 30 days?