montecatini

INTAKE APPLICATION

Name: _____ DOB: _____ Age: _____ Today's Date: _____
Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed
Home Phone Number: _____ Mobile Phone Number: _____
Email Address: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
SSN of Patient (required): _____ SSN of Guarantor (required): _____

Where did you hear about Montecatini?

1. Why have you contacted us now (has something changed recently)? _____

2. How long have you had problems with food/eating disorder symptoms? _____
   Have there been periods of recovery during that time? ☐ Yes ☐ No

3. One a scale of 1-10, how motivated are you to receive treatment at this time (10 being extremely motivated)?
   _____

4. On a scale of 1-10, how much do you fear gaining weight (10 being extremely afraid)? _____

5. Height: ____ ft ____ in Current Weight: _____ lbs BMI: _____

   Any weight changes in the last 6 months? ☐ Yes ☐ No If so, how much increase or decrease? _____
   Highest known weight: _____ lbs Lowest known weight: _____lbs

6. Does your body size or shape disturb you? ☐ Yes ☐ No

For questions 7-10, please indicate your behavior for the last 30 days. If you are currently in treatment, please answer regarding your behaviors prior to entering treatment.

7. On average how many days per week do you restrict your food?
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
   How long have you been actively restricting your food? _____
   If you restrict calories, how many calories do you limit yourself to each day? _____

8. On average, how many days per week do you purge your food?
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
   If you purge multiple times a day, how many times a day you purge?
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

   Do you purge by vomiting? ☐ Yes ☐ No

   Do you purge by laxative use? ☐ Yes ☐ No
   If yes, how many times per week on average do you use laxatives? _____
   If yes, how many pills do you take each time you use laxatives? _____

Do you purge by a diuretic use? ☐ Yes ☐ No
If yes, how many times per week on average do you use diuretics? _____
If yes, how many pills do you take each time you use diuretics? _____

Do you use diet pills? ☐ Yes ☐ No
If yes, how many times per week on average do you use diet pills? _____
If yes, how many pills on average do you take each time you use diet pills? _____

Do you purge by enema use? ☐ Yes ☐ No
Describe a typical episode of purging (i.e. time of day, only after binge, etc.):

_____

How long have you been actively purging your food? _____

9. On average, how many days per week do you binge?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
How long have you been actively binging? _____

Describe a typical episode of binging (i.e., time of day, foods typically consumed, eating an extra meal, etc.):

_____

10. On average, how many days per week do you exercise (for any length of time, including any sports practice or consistent body movement that you might do for your employment)?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
On average, how many hours per day do you exercise? _____
Do you exercise during the night? ☐ Yes ☐ No
Do you feel you exercise ☐ for enjoyment–or ☐ to compensate for food consumed?

11. Have you ever had other problems with eating or attempts to control your eating, which has not been covered so far (i.e, intestinal bypass, substance abuse, etc.)? ☐ Yes ☐ No If yes, please explain:

_____

12. **Substance abuse history:** Fill in below where applicable–or ☐ None

	Historical Use		Current Use		Frequency	Amount	Last Used
	Yes	No	Yes	No			
Marijuana	☐	☐	☐	☐			
Cocaine/Crack	☐	☐	☐	☐			
Methamphetamines	☐	☐	☐	☐			
Barbiturates	☐	☐	☐	☐			
Heroin	☐	☐	☐	☐			
PCP	☐	☐	☐	☐			
Hallucinogens	☐	☐	☐	☐			
Tranquilizers	☐	☐	☐	☐			
Benzodiazepines	☐	☐	☐	☐			
Inhalants	☐	☐	☐	☐			
Alcohol	☐	☐	☐	☐			
Opiates	☐	☐	☐	☐			
Synthetics (i.e. bath salts)	☐	☐	☐	☐			
OTC (cold/cough) meds	☐	☐	☐	☐			
Cigarettes	☐	☐	☐	☐			

13. Are you currently taking any medication? ☐ Yes ☐ No If yes, please list (use more paper if needed)

Name of Medicine (i.e., Abilify)	Dose (i.e., 10mg)	Frequency (i.e., Daily)

* *If you are taking medication, who is your prescribing physician?* _____

14. Do you experience significant mood swings? ☐ Yes ☐ No

15. Have you been diagnosed with ☐ anxiety ☐ depression ☐ bipolar disorder ☐ OCD ☐ PTSD

16. Are you currently having suicidal thoughts?
    - Passive (i.e, "it would be easier if I weren't alive.") ☐ Yes ☐ No
    - Active (i.e., "I am having thoughts about ending my life.") ☐ Yes ☐ No

    Have you been suicidal in the past? ☐ Yes ☐ No
    If yes, how many times? _____

17. Are you currently engaging in self-harm behaviors (i.e., burning, cutting, hitting)? ☐ Yes ☐ No
    If yes, how many days per week, on average, are you engaging in self-harm behaviors?
    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
    How long have you been actively self-harming? _____

18. Are you able to commit to safety while at Montecatini? ☐ Yes ☐ No

19. Please tell us about your prior *eating disorder treatment*. Have you ever had:

Individual Therapy (Outpatient)

Place	Type (i.e. therapist, dietician)	Length of Stay	Reason for Treatment

Intensive Outpatient

Place	Dates	Length of Stay	Reason for Treatment

Day Treatment/Partial Hospitalization

Place	Dates	Length of Stay	Reason for Treatment

Residential Treatment

Place	Dates	Length of Stay	Reason for Treatment

Inpatient (Psychiatric) Treatment

Place	Dates	Length of Stay	Reason for Treatment

Inpatient (Medical) Treatment

Place	Dates	Length of Stay	Reason for Treatment

20. Do you ever exhibit periods of verbal or physical anger/rage/aggression? ☐ Yes ☐ No

21. Please list any allergies (food or non-food)–must provide medical documentation:

_____

If so, what is the reaction?

_____

Please list any food intolerance:

_____

Please list any food restrictions that you observe as part of your religion:

_____

22. Are there cultural, religious, or spiritual considerations we should be aware of? If yes, please describe:

_____

23. Do you require any assistive devices (hearing aids, wheelchairs, etc.) or a translator? If yes, please explain:

_____

24. Do you eat any non-food items? ☐ Yes ☐ No If yes, please list:

_____

25. How has your eating disorder affected you medically?

26. Is there anything we haven't asked that you believe we need to know in assisting you with the most appropriate treatment recommendations?

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