Intake Application

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

INSURANCE SUBSCRIBER INFORMATION:
Name: _____ Address: _____ Phone: _____ DOB: _____ SSN: _______

GUARANTOR (financially responsible party) INFORMATION:
Name: _____ Address: _____ Phone: _____ DOB: _____ SSN: _______

Do you have Medicare and/or a secondary insurance? ☐ Yes ☐ No _____

Where did you hear about Montecatini? _____
If internet, specifically: ☐ Google ☐ Bing ☐ Yahoo ☐ Facebook ☐ Psychology Today
☐ ED Referral.com ☐ Other website: _____

1) If an adolescent, are parents divorced? ☐ Yes ☐ No - If yes, we will need copy of custody agreement. _____

2) Are you held under any conservatorship or guardianship? ☐ Yes ☐ No Name of conservator/ guardian: _____ ***If yes, see extra form.*** *(We will need a copy of the court order prior to admission)*

3) Do you have any legal issues? ☐ Yes ☐ No - *If yes, we will need information on parole/legal situation.* _____

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

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

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

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

8) Height: _____ ft _____ in Current weight: _____ BMI: _____

Highest adult (no pregnancy) weight: _____ Lowest adult weight: _____ Comments: _____

Any weight changes in the last 6 months? ☐ Yes ☐ No If yes, how much increase or decrease? _____

9) Do you require a vegetarian diet? _____

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

11) Please list any food intolerances: _____

12) Please list any allergies -- food (must provide medical documentation) or non-food:

Allergic to (item)	Reaction

13) Do you have documentation from a doctor regarding your allergies/intolerances/food restrictions? _____

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

☐ *I'm currently in treatment.*
If currently in treatment, are you engaging in behaviors? If yes, please describe: _______

14) On average how many days per week do you restrict your food?
☐ 0 ☐ 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? _____

15) On average, how many days per week do you purge your food?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 _____

If you purge multiple times a day, how many times a day you purge?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+ _____

Do you purge by vomiting? ☐ Yes ☐ No _____

Do you purge by laxative use? ☐ Yes ☐ No _____
Times per week?
Number of pills taken each time? _____

Do you purge by diuretic use? ☐ Yes ☐ No _____
Times per week? _____
Number of pills taken at each time? _____

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

Do you purge by enema use? ☐ Yes ☐ No _____

How long have you been actively purging? _____

16) On average how many days per week do you binge? _____

☐ 0 ☐ 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.): _____

Do you binge during the night? ☐ Yes ☐ No _____

17) 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)?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 _____

On average, how many minutes/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? _____

18) Have you ever attempted to control your eating, which has not been covered so far (i.e., chew/spit bx, intestinal bypass, caffeine use, chewing gum or ice, substance abuse, etc.)? ☐ Yes ☐ No If yes, please explain: _____

19) 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	☐	☐	☐	☐			
Other amphetamines (Adderall): _____	☐	☐	☐	☐			
Barbiturates (Amytal, Nembutal, Seconal)	☐	☐	☐	☐			
Heroin	☐	☐	☐	☐			
PCP	☐	☐	☐	☐			
Hallucinogens	☐	☐	☐	☐			
Benzodiazepines (Valium, Ativan, Xanex)	☐	☐	☐	☐			
Inhalants	☐	☐	☐	☐			
Alcohol: ☐ beer, ☐ liquor, ☐ wine	☐	☐	☐	☐			
Opiates: _____	☐	☐	☐	☐			
Synthetics (bath salts, etc.)	☐	☐	☐	☐			
OTC meds (cold/cough) (specify): _____	☐	☐	☐	☐			
Cigarettes	☐	☐	☐	☐			

20) Are you currently taking any medication? ☐ Yes ☐ No If yes, please list *(use more paper if more room is needed)* Comments: _____

Name of Medicine *(Example: Abilify)*	**Dose** *(i.e., 10mg)*	**Frequency** *(i.e. daily)*

Name of Medicine *(Example: Abilify)*	**Dose** *(i.e., 10mg)*	**Frequency** *(i.e. daily)*

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

Please note: Some medications may be altered or withdrawn after your meeting with our Medical Team. ☐

21) Do you experience significant mood swings? ☐ Yes ☐ No _____

22) Do you ever exhibit periods of verbal or physical anger or aggression? ☐ Yes ☐ No ☐ Inwardly ☐ Outwardly _____

23) Have you been diagnosed with: ☐ anxiety ☐ depression ☐ Bipolar disorder ☐ OCD ☐ PTSD _____

24) Are you currently having suicidal thoughts? Comment: _____
   a. *Passive* (i.e., "It would be easier if I weren't alive.") ☐ Yes ☐ No
   b. *Active* (i.e., "I am having thoughts about ending my life.") ☐ Yes ☐ No
   Have been suicidal in the past? ☐ Yes ☐ No If yes, how many times? _____

25) 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?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 _____

   How long have you been actively self-harming? _____

26) Are you able to commit to safety while at Montecatini? ☐ Yes ☐ No _____

Please tell us about your prior eating disorder treatment. ☐ None Have you ever had:
Individual therapy (outpatient):

Name/Place	Type: therapist, dietician, psychiatrist, PCP, etc.	Dates	Reason for Treatment

If admitting directly into IOP, do you have an outpatient psychiatrist (required)? ☐ Yes ☐ No _____

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):

Place	Dates	Length of Stay	Reason for Treatment

Inpatient (medical):

Place	Dates	Length of Stay	Reason for Treatment

☐ Additional treatment history – see end of form.

27) Can you walk up and down stairs and shower/dress by yourself? ☐ Yes ☐ No _____

28) If you are currently in a medical hospital or inpatient acute:
    Are you eating solid food? ☐ Yes ☐ No _____

29) Have you ever left any of the above facilities AMA? ☐ Yes ☐ No _____

30) Are there any cultural, religious, or spiritual considerations we should be aware of? _____

31) Do you require any assistive devices (hearing aids, wheelchair, etc.) or translator? _____

32) Do you eat any non-food items? ☐ Yes ☐ No If yes, please list: _____

33) How has your eating disorder affected you medically (tube feeding, refeeding, abnormal EKGs/cardiac problems, ER for fluids, etc.)? _____

34) What is your plan for aftercare (stay with Montecatini for step-down, return to referring facility, transfer elsewhere)? _____

35) Do you have any relationship dynamics or family circumstances that may impact your treatment? _____

36) *Reminder to Admissions Coordinator*- have you let the client know about Friends and Family Weekend?
    ☐ Yes ☐ No _____

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

Additional ED Treatment History:

LOC & Place	Dates	Length of Stay	Reason for Treatment