clementine
A MONTE NIDO AFFILIATE *for adolescents*

INTAKE QUESTIONNAIRE

NAME AGE REFERENT

WHY TREATMENT NOW? IMPACT OF PRIOR TREATMENT EXPERIENCES

TELL US WHY YOU ARE PURSUING TREATMENT AT THIS TIME:

WHAT ASPECTS OF BEING IN TREATMENT CONCERN YOU?

IF YOU HAVE BEEN IN TREATMENT PREVIOUSLY, WHAT ARE SOME OF THE POSITIVE OR NEGATIVE EXPERIENCES THAT MAY IMPACT YOUR EXPERIENCE AT CLEMENTINE?

FAMILY AND HOME ENVIRONMENT

DO YOU LIVE WITH YOUR PARENTS? ☐ YES ☐ NO

HAVE YOU EVER LIVED AWAY FROM YOUR PARENTS? ☐ YES ☐ NO

IF YES, UNDER WHAT CIRCUMSTANCES?

PLEASE LIST ALL THE INDIVIDUALS LIVING AT HOME WITH YOU:

Name	*Age*	*Relationship to you*	*How do you get along?*

HOW DO YOU FEEL YOUR CURRENT LIVING ENVIRONMENT IMPACTS YOU?

DO YOU HAVE ANY BROTHERS/SISTERS, STEP-BROTHERS/SISTERS, OR HALF-BROTHERS/SISTERS WHO DO NOT LIVE WITH YOU? ☐ YES ☐ NO

PLEASE LIST ANY OTHER INDIVIDUALS WHO ARE IMPORTANT IN YOUR LIFE *(E.G.; IMMEDIATE FAMILY, RELATIVES, SIGNIFICANT OTHERS)*:

Name	*Age*	*Relationship to you*	*How do you get along?*

SOCIAL ENVIRONMENT

DO YOU HAVE A BELIEF SYSTEM *(E.G.; CULTURAL, MORAL, SPIRITUAL, RELIGIOUS, ETC.)* WHICH INFLUENCES YOUR LIFE? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

WHO IS IN YOUR SUPPORT SYSTEM / GIVES YOU EMOTIONAL SUPPORT *(E.G., FAMILY, FRIENDS, THERAPIST)*?

HOW DO YOU GET ALONG WITH YOUR FRIENDS?

HAS THERE BEEN A CHANGE IN YOUR CIRCLE OF FRIENDS RECENTLY? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

PLEASE LIST YOUR PRESENT AND PAST BOYFRIEND(S) OR GIRLFRIEND(S):

First name	*Amount of time together*	*Reason for ending the relationship*

LIFE EXPERIENCES

WHICH EXPERIENCES AND EVENTS IN YOUR LIFE WHILE GROWING UP HAVE HAD AN AFFECT ON YOU?

WHAT HAVE BEEN THE LOSSES, CHANGES, CRISES, AND/OR TRANSITIONS IN YOUR LIFE?

CAN YOU DESCRIBE A TYPICAL OR RECENT DAY IN YOUR LIFE THAT WOULD HELP US UNDERSTAND YOU?

EDUCATIONAL HISTORY

WHAT IS THE HIGHEST GRADE YOU HAVE COMPLETED?

DO YOU HAVE ANY PROBLEMS IN SCHOOL? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

HAVE YOU EVER REPEATED OR SKIPPED A GRADE? ☐ YES ☐ NO

IF YES, WHICH ONE?

HAVE YOU EVER DROPPED OUT, BEEN EXPELLED OR SUSPENDED? ☐ YES ☐ NO

IF YES, WHICH ONE AND WHAT HAPPENED?

HOW HAS YOUR ATTENDANCE BEEN? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

WHAT ARE YOUR GRADES LIKE? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

HAVE THEY CHANGED A LOT? ☐ YES ☐ NO

DO YOU HAVE LEARNING DIFFICULTIES OR ATTEND SPECIAL CLASSES? ☐ YES ☐ NO

HAVE YOU EVER HAD PSYCHOLOGICAL TESTING? ☐ YES ☐ NO

LEGAL HISTORY

HAVE YOU EVER BEEN INVOLVED, ARE CURRENTLY INVOLVED, OR ANTICIPATE INVOLVEMENT WITH THE LEGAL SYSTEM *(E.G.; CRIMINAL, DIVORCE, CUSTODY, CIVIL, ETC.)*? ☐ YES ☐ NO

IF YES, IN WHAT WAY?

ADDITIONAL BACKGROUND INFORMATION

ARE YOU INVOLVED IN ANY SPORTS OR EXERCISE?

WHAT MOTIVATES / MOTIVATED YOU TO PARTICIPATE IN SPORTS OR EXERCISE?

DO YOU HAVE ANY PARTICULAR INTERESTS, PASSIONS, OR HOBBIES THAT YOU CAN TELL US ABOUT?

DO YOU HAVE ANY DIETARY REQUIREMENTS DUE TO RELIGION *(E.G., KOSHER)* OR MEDICAL CONDITION YOU HAVE DOCUMENTATION FOR *(E.G., DIABETES, FOOD ALLERGIES)*?

HAVE YOU BEEN FED BY NON-ORAL ROUTES AND / OR RECEIVED SUPPLEMENTS AS YOUR PRIMARY SOURCE OF NUTRITION? IF SO, PLEASE PROVIDE DETAILS:

EATING DISORDER SYMPTOMS

HEIGHT CURRENT WEIGHT

USUAL WEIGHT DESIRED WEIGHT

HIGHEST WEIGHT / AGE LOWEST WEIGHT / AGE

WEIGHT BEFORE ONSET OF EATING DISORDER / AGE

RECENT WEIGHT CHANGES *(DESCRIBE WEIGHT LOSS OR GAIN PATTERNS OVER THE PAST 12 MONTHS)*

CURRENT CALORIC INTAKE *(INCLUDING SUPPLEMENTS)*

DO YOU RESTRICT YOUR FOOD INTAKE?
☐ NO ☐ YES, BUT ONLY IN THE PAST *(WHEN DID YOU STOP?)* ☐ YES, I CURRENTLY RESTRICT

IF YES, HOW DO YOU / DID YOU RESTRICT *(E.G., CALORIES, FASTING, SPECIFIC FOOD AVOIDANCE)*?

DO YOU BINGE EAT? *(BINGE EATING IS DEFINED AS EATING AN AMOUNT OF FOOD THAT IS LARGER THAN THE AVERAGE PERSON WOULD CONSUME, ACCOMPANIED BY A SENSE OF BEING OUT OF CONTROL.)*
☐ NO ☐ YES, BUT ONLY IN THE PAST *(WHEN DID YOU STOP?)* ☐ YES, I CURRENTLY BINGE

IF YES, HOW OFTEN DO YOU / DID YOU BINGE PER DAY / WEEK ON AVERAGE?

DO YOU HAVE OTHER OVER-EATING PATTERNS SUCH AS "GRAZING" ON FOOD ALL DAY?

WHAT ARE YOUR PREFERRED BINGEING AND / OR GRAZING FOODS?

DO YOU PURGE?
☐ NO ☐ YES, BUT ONLY IN THE PAST *(WHEN DID YOU STOP?)* ☐ YES, I CURRENTLY PURGE

IF YES, HOW OFTEN DO YOU / DID YOU PURGE PER DAY / WEEK ON AVERAGE?

DO YOU ABUSE LAXATIVES?
☐ NO ☐ YES, BUT ONLY IN THE PAST *(WHEN DID YOU STOP?)* ☐ YES, I CURRENTLY ABUSE

IF YES, WHAT KIND OF LAXATIVES DO YOU / DID YOU USE, AND WHAT AMOUNT PER DAY / WEEK ON AVERAGE?

DO YOU CURRENTLY USE WEIGHT-LOSS PILLS? ☐ NO ☐ YES

IF YES, LIST TYPE, QUANTITY, AND FREQUENCY

DO YOU DRINK AN EXCESSIVE AMOUNT OF WATER? ☐ NO ☐ YES

DO YOU HAVE ANY FOOD RITUALS THAT CONCERN YOU? ☐ NO ☐ YES

IF YES, PLEASE EXPLAIN:

DO YOU HAVE AN UNHEALTHY RELATIONSHIP WITH EXERCISE?

☐ NO

☐ YES, I GET ANXIOUS OR IRRITABLE IF I CAN'T ENGAGE IN MY EXERCISE ROUTINE

☐ YES, I OVER-EXERCISE *(HOW MANY HOURS PER DAY / WEEK?)*

☐ YES, I EXERCISE AGAINST THE ADVICE OF A HEALTH CARE PROVIDER AND / OR DESPITE PAIN

☐ YES, I UNDER-EXERCISE

EXPOSURE TO TRAUMA

HAVE YOU BEEN PHYSICALLY ABUSED? ☐ NO ☐ YES

HAVE YOU BEEN SEXUALLY ABUSED? ☐ NO ☐ YES

DOES ANYONE IN YOUR FAMILY STRUGGLE WITH SUBSTANCE ABUSE, A MENTAL HEALTH ISSUE, OR AN EATING DISORDER? ☐ NO ☐ YES

HAVE YOU LOST A CLOSE FAMILY MEMBER? ☐ NO ☐ YES

OTHER:

PRIOR TREATMENT EXPERIENCES *(LIST PLACES, DATES, AND HOW THEY IMPACTED YOU)*

INDIVIDUAL THERAPY

INTENSIVE OUTPATIENT

DAY TREATMENT / PARTIAL HOSPITALIZATION

RESIDENTIAL

INPATIENT PSYCHIATRIC

INPATIENT MEDICAL

CO-OCCURRING CONDITIONS

LET US KNOW IF YOU HAVE EVER BEEN DIAGNOSED WITH AND / OR HAVE EXPERIENCED ANY OF THE FOLLOWING CONDITIONS THAT SOMETIMES ACCOMPANY EATING DISORDERS:

DEPRESSION	☐ NO	☐ YES
BIPOLAR DISORDER / MANIA / HYPOMANIA / EXTREME MOOD FLUCTUATION	☐ NO	☐ YES
PREMENSTRUAL SYMPTOMS	☐ NO	☐ YES
POSTMENOPAUSAL SYMPTOMS	☐ NO	☐ YES
ATTENTION DEFICIT DISORDER	☐ NO	☐ YES
PANIC DISORDER	☐ NO	☐ YES
SOCIAL PHOBIA	☐ NO	☐ YES
ANXIETY DISORDER	☐ NO	☐ YES
OBSESSIVE COMPULSIVE DISORDER	☐ NO	☐ YES
OTHER IMPULSIVE DISORDER *(E.G., SHOPPING, SEXUAL IMPULSIVITY, GAMBLING)*	☐ NO	☐ YES
EXCESSIVE/DISRUPTIVE USE OF INTERNET OR COMPUTER GAMES	☐ NO	☐ YES
SUBSTANCE ABUSE	☐ NO	☐ YES
ALCOHOL ABUSE	☐ NO	☐ YES
HOARDING *(OF FOOD OR POSSESSIONS)*	☐ NO	☐ YES
SHOPLIFTING OR STEALING	☐ NO	☐ YES
ANXIETY OR INABILITY TO SHOP FOR FOOD AND / OR CLOTHING	☐ NO	☐ YES
ANXIETY OR INABILITY TO EAT IN RESTAURANTS OR TAKE-OUT FOODS	☐ NO	☐ YES

OTHER:

SELF-HARM

DO YOU HAVE SUICIDAL THOUGHTS? ☐ NO ☐ YES

HAVE YOU EVER TRIED TO COMMIT SUICIDE? ☐ NO ☐ YES

IF YES, HOW AND WHEN?

DO YOU DO OTHER SELF-HARMING BEHAVIORS *(E.G., CUTTING, BURNING, PICKING)*? ☐ NO ☐ YES

IF YES, WHERE ON YOUR BODY?

CAN YOU COMMIT TO SAFETY WHILE UNDER THE CARE OF CLEMENTINE? ☐ NO ☐ YES

PSYCHIATRIC MEDICATION HISTORY

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION DOSE DURATION

MEDICATION DOSE DURATION

MEDICATION DOSE DURATION

MEDICATION DOSE DURATION

WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST? (PROVIDE WHATEVER INFORMATION YOU REMEMBER)

MEDICATION DOSE DURATION

MEDICATION DOSE DURATION

MEDICATION DOSE DURATION

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM

CURRENT MEDICAL CONDITIONS

CURRENT MEDICATIONS FOR ANY MEDICAL CONDITIONS

AGE OF ONSET OF MENSES / LAST MENSTRUAL PERIOD

PAST AND / OR RESOLVED MEDICAL CONDITIONS

PAST MEDICAL HOSPITALIZATIONS

SERIOUS INJURIES TO THE SPINE OR HEAD

ADDITIONAL INFORMATION

YOU MAY EXPERIENCE PERSONAL STRUGGLES DURING YOUR TREATMENT. DO YOU FEEL IT WILL BE DIFFICULT TO SHARE THOSE STRUGGLES WITH US? IF SO, PLEASE EXPLAIN:

PLEASE LIST THREE PROMINENT STRESSORS YOU HAVE AT THIS TIME:

1. _____

2. _____

3. _____

WHAT ARE SOME STRENGTHS AND WEAKNESSES YOU HAVE THAT MAY INFLUENCE THE COURSE OF YOUR TREATMENT?

STRENGTHS:

1. _____

2. _____

3. _____

AREAS OF STRUGGLE:

1. _____

2. _____

3. _____

WHAT ARE SOME GOALS YOU HAVE AT THIS TIME?

SHORT-TERM:

1. _____

2. _____

3. _____

LONG-TERM:

1. _____

2. _____

3. _____

PROSPECTIVE PATIENT

SIGNATURE _____ DATE _____

PHONE _____

CLEMENTINE STAFF

NAME _____

SIGNATURE _____ DATE _____