

## PARENT INTAKE QUESTIONNAIRE

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

YOUR NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

### BACKGROUND

WHAT PROMPTED YOU TO SEEK EATING DISORDER TREATMENT FOR YOUR CHILD? \_\_\_\_\_

WHAT ARE YOUR PRIMARY CONCERNS? \_\_\_\_\_

### PHYSICAL HEALTH

WHO IS YOUR CHILD'S PRIMARY HEALTH CARE PROVIDER (I.E.; PHYSICIAN, NURSE, OB/GYN)? \_\_\_\_\_

WHEN WAS YOUR CHILD'S LAST PHYSICAL? \_\_\_\_\_

HAS YOUR CHILD EVER BEEN HOSPITALIZED?  YES  NO  I DON'T KNOW / UNSURE

HAS YOUR CHILD EVER HAD SURGERY?  YES  NO  I DON'T KNOW / UNSURE

PLEASE LIST ANY PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER DRUGS, VITAMINS, AND/OR HERBAL SUPPLEMENTS YOUR CHILD CURRENTLY TAKES AND DOSAGES, IF KNOWN: \_\_\_\_\_

HAS YOUR CHILD BEGUN MENSES?  YES  NO  I DON'T KNOW / UNSURE

IF YES, APPROXIMATE AGE AT ONSET: \_\_\_\_\_

HAS SHE EXPERIENCED ANY INTERRUPTION IN MENSES?  YES  NO  I DON'T KNOW / UNSURE

WERE THERE ANY COMPLICATIONS RELATED TO PREGNANCY AND/OR DELIVERY OF YOUR CHILD?

YES  NO

IF YES, PLEASE DESCRIBE:

DID YOUR CHILD HAVE ANY HEALTH PROBLEMS IMMEDIATELY AFTER BIRTH?

YES  NO

IF YES, PLEASE DESCRIBE:

DOES YOUR CHILD HAVE ANY CHRONIC HEALTH CONDITIONS?

YES  NO

IF YES, PLEASE DESCRIBE:

HAS YOUR CHILD HAD ANY SIGNIFICANT INJURIES OR ILLNESSES?

YES  NO

IF YES, PLEASE DESCRIBE:

## HISTORY

WAS YOUR CHILD ADOPTED?

NO  YES

WHO HAVE BEEN YOUR CHILD'S PRIMARY CAREGIVERS?

WHERE DID YOUR CHILD GROW UP/ SPEND MOST OF HER CHILDHOOD?

BRIEFLY DESCRIBE YOUR CHILD'S TODDLER YEARS

(E.G.; EASY / DIFFICULT TO CARE FOR, EATING DIFFICULTIES, ETC.):

BRIEFLY DESCRIBE YOUR CHILD'S EARLY SCHOOL YEARS (E.G.; ADJUSTMENT TO SCHOOL, FRIENDSHIPS, ETC.):

PLEASE INDICATE THE PRESENCE OF THE FOLLOWING CONDITIONS IN YOUR CHILD'S HISTORY OR FAMILY HISTORY BY MARKING WITH AN X:

<i>Condition</i>	<i>Client</i>	<i>Biological mother</i>	<i>Biological father</i>	<i>Biological sibling</i>	<i>Maternal grandmother</i>	<i>Maternal grandfather</i>	<i>Paternal grandmother</i>	<i>Paternal grandfather</i>
<b>MENTAL HEALTH</b>								
DEPRESSION								
ANXIETY								
EATING DISORDER								
BIPOLAR DISORDER								
DRUG / ALCOHOL ABUSE								
SUICIDE / ATTEMPT								
PSYCHIATRIC HOSPITALIZATION								
<b>GENERAL HEALTH</b>								
ALLERGIES								
ALZHEIMER'S DEMENTIA								
ASTHMA								
CANCER								
DEVELOPMENTAL DISABILITY								
DIABETES								
EPILEPSY								
HEART DISEASE								
HIGH CHOLESTEROL								
HIGH BLOOD PRESSURE								
STROKE								
OTHER:								

WHAT EATING-RELATED SYMPTOMS OR BEHAVIORS HAS YOUR CHILD EXHIBITED THAT CONCERN YOU?

OVEREATING / BINGE EATING  CURRENT  PAST

PURGING (VOMITING, LAXATIVE USE, ETC.)  CURRENT  PAST

UNDER-EATING / RESTRICTING FOOD INTAKE  CURRENT  PAST

EXCESSIVE OR COMPULSIVE EXERCISE  CURRENT  PAST

OTHER:  CURRENT  PAST

DOES YOUR CHILD DRINK ALCOHOLIC BEVERAGES?  YES  NO  I DON'T KNOW / UNSURE

IF YES, HOW OFTEN?  TIMES PER DAY  TIMES PER WEEK  TIMES PER MONTH

DOES YOUR CHILD CURRENTLY USE ILLEGAL DRUGS OR PRESCRIPTION DRUGS NOT AS PRESCRIBED?  
 YES  NO  I DON'T KNOW / UNSURE

IF YES, HOW OFTEN?  TIMES PER DAY  TIMES PER WEEK  TIMES PER MONTH

HAS YOUR CHILD EVER BEEN EVALUATED OR TREATED FOR DRINKING OR DRUG USE?

YES  NO  I DON'T KNOW / UNSURE

IF YES, PLEASE DESCRIBE:

DOES YOUR CHILD SMOKE CIGARETTES OR USE TOBACCO PRODUCTS?

YES  NO  I DON'T KNOW / UNSURE

IF YES, HOW OFTEN?  TIMES PER DAY  TIMES PER WEEK  TIMES PER MONTH

DOES YOUR CHILD INGEST CAFFEINE?

YES  NO  I DON'T KNOW / UNSURE

IF YES, HOW OFTEN?  TIMES PER DAY  TIMES PER WEEK  TIMES PER MONTH

#### EXPOSURE TO TRAUMA

HAS YOUR CHILD BEEN PHYSICALLY ABUSED?

YES  NO  I DON'T KNOW / UNSURE

IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD BEEN SEXUALLY ABUSED?

YES  NO  I DON'T KNOW / UNSURE

IF YES, PLEASE EXPLAIN:

#### PARENT/GUARDIAN #1 INFORMATION

NAME

OCCUPATION

MARITAL HISTORY

#### PARENT/GUARDIAN #2 INFORMATION

NAME

OCCUPATION

MARITAL HISTORY

## FAMILY AND HOME ENVIRONMENT

HOW MANY CHILDREN ARE IN YOUR CHILD'S IMMEDIATE FAMILY? \_\_\_\_\_

WHERE DOES SHE FALL IN BIRTH ORDER (I.E.; FIRST, MIDDLE, ETC.)? \_\_\_\_\_

PLEASE LIST ALL THE INDIVIDUALS LIVING AT HOME WITH YOUR CHILD AND ANY IMMEDIATE FAMILY MEMBERS NOT LIVING IN THE HOME:

Name	Age	Relationship to client	Lives in the home with client?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

DESCRIBE ANY RELIGIOUS AFFILIATION OR SPIRITUAL BELIEFS; THEIR IMPACT, IF ANY, ON YOUR CHILD; AND ANY SERVICE PREFERENCES YOUR CHILD MAY HAVE: \_\_\_\_\_

YOUR CHILD'S ETHNICITY/ CULTURAL IDENTIFICATION: \_\_\_\_\_

PLEASE DESCRIBE ANY SIGNIFICANT/ STRESSFUL EVENTS IN YOUR CHILD'S LIFE RIGHT NOW OR IN THE RECENT PAST (E.G.; LOSSES, MOVES, CHANGES IN FAMILY STRUCTURE, ETC.): \_\_\_\_\_

PLEASE LIST YOUR CHILD'S STRENGTHS: \_\_\_\_\_

IS THERE ANYTHING ELSE YOU BELIEVE IS IMPORTANT FOR US TO KNOW RIGHT NOW? \_\_\_\_\_