clementine
A MONTE NIDO AFFILIATE *for adolescents*

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:

Condition	*Client*	*Biological mother*	*Biological father*	*Biological sibling*	*Maternal grandmother*	*Maternal grandfather*	*Paternal grandmother*	*Paternal grandfather*
MENTAL HEALTH								
DEPRESSION								
ANXIETY								
EATING DISORDER								
BIPOLAR DISORDER								
DRUG / ALCOHOL ABUSE								
SUICIDE / ATTEMPT								
PSYCHIATRIC HOSPITALIZATION								
GENERAL HEALTH								
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?*
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ 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?