Adolescent/Adult Initial Assessment

Whenever possible please have the individual completing the assessment fill out this form. The following information will assist our clinical staff with getting to know you and completing the initial assessment appointment. **It is very important to fill this out as completely as possible prior to your initial appointment**. Providers may ask you to fill this out prior to being seen. Please use black ink.

Date	Legal name	Preferred name

What sex were you assigned at birth? ☐ Male ☐ Female	Gender identity

What pronouns should we use to refer to you while you are in our care?
☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

What prompted you to schedule an Eating Disorder Assessment at Melrose Center? _____

Please list the name of who referred you to Melrose Center? What is their relationship to you?

I have heard about Melrose Center from (check all that apply):

- ☐ Friend/Family/Neighbor
- ☐ Advertisement (Radio, print, billboard)
- ☐ Online (Facebook, website, search)
- ☐ Medical or Mental Health Provider
- ☐ School Social Worker or Counselor
- ☐ Other _____

PLEASE COMPLETE FOR 18 YEARS AND YOUNGER

Current living arrangements

- ☐ Lives with both parents (biological or adoptive) in same household
- ☐ Single parent
- ☐ Shared custody (parents in different households) primary residence _____
- ☐ Relative/guardian's home
- ☐ Other, describe _____
- ☐ Hospital
- ☐ Residential care
- ☐ Temporary housing
- ☐ Friend's home
- ☐ Homeless

Is your child adopted? ☐ No ☐ Yes. If yes, how old was your child at the time of adoption? _____

Is your child aware of the adoption? ☐ No ☐ Yes

FAMILY ENVIRONMENT/RELATIONSHIPS

Are any other issues seriously affecting your family of which you would like us to be aware?

Has your child ever experienced or witnessed any of the following?

☐ Domestic violence/abuse ☐ Emotional abuse ☐ Physical abuse
☐ Community violence ☐ Physical neglect ☐ Fire
☐ Sexual assault/molestation ☐ Natural disasters ☐ Other _____

☐ Yes ☐ No Have you or your child been involved with any of the following county resources?

☐ PCA (Personal Care Assistance) ☐ PACER (Parent Advocacy Coalition for Educational Rights)
☐ Foster care ☐ The ARC
☐ County social worker ☐ Developmental disorder social worker
☐ Respite care ☐ Other _____

☐ Yes ☐ No Does your child have a history of legal charges? Please describe.

_____

☐ Yes ☐ No Is your child currently on probation?

☐ Yes ☐ No Has your child ever been on probation?

☐ Yes ☐ No Has your child ever been court-ordered into chemical health or mental health treatment?

☐ Yes ☐ No Has your child ever had involvement with Child Protection Services (CPS)? Please describe.

_____

Name of CPS caseworker(s) assigned to family (if applicable)

☐ None reported _____

Name of guardian ad litem (GAL) or court appointed special advocate (CASA) assigned to family?

☐ None reported

END 18 YEARS AND YOUNGER SECTION

What eating – related symptoms or behaviors do you experience?

	Current & Frequency	Past & Frequency
Overeating/Emotional Eating/Binge eating		
Purging (self-induced vomiting)		
Restricting food / under-eating		
Compulsive or excessive exercise		
Diet pills / supplements or weight loss programs		
Hiding food		
Excessively Picky eater		
Laxative use		

Please list your highest and lowest weights:

Highest weight _____ Age at highest weight _____
Lowest weight _____ Age at lowest weight _____

When did you first notice you had a problem with your eating and what was going on in your life then?

_____

_____

_____

_____

Eating Pattern (over past 1 month)

Breakfast _____

Snack (a.m.) _____

Lunch _____

Snack (p.m.) _____

Dinner _____

Snack (evening) _____

Fluid intake _____

What foods do you avoid? _____

What rules do you follow around eating? _____

_____

☐ Yes ☐ No Have you experienced any negative incidents in your life related to weight, diets, or eating? Please explain:

_____

_____

_____

What percent of the waking day do you spend thinking about food, weight and/or body image?

- ☐ 75-100% All day
- ☐ 50-74% Over half your day
- ☐ 25-49% Quarter to half of your day
- ☐ Less than 25% of each day

How many times a week do you exercise and for how long? _____

Who do you live with? _____

☐ Single ☐ Married, how long: _____ ☐ Widowed, how long: _____
☐ Domestic partnership ☐ Divorced, how long: _____

Sexual orientation? _____ Do you have children? _____

Employment status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

If applicable, occupation/type of work/jobs: _____

☐ Yes ☐ No Do you consume alcohol? If yes, how many drinks per day? _____

☐ Yes ☐ No Have you ever felt you should cut down on your drinking?

☐ Yes ☐ No Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

☐ Yes ☐ No Have you ever had head trauma that resulted in loss of consciousness?

☐ Yes ☐ No Have you ever used street drugs or illicit? If yes, are you currently using? ☐ Yes ☐ No

☐ Yes ☐ No Do you smoke cigarettes? If yes, how much per day? _____

☐ Yes ☐ No Have you ever used other tobacco products?

☐ Yes ☐ No Do you drink caffeine products? If yes, how many drinks per day? _____

Please list all of your medications, or bring a list with you of all prescribed, over the counter drugs, vitamins and/or herbal supplements that you currently take:

_____

_____

_____

_____

_____

Who is your primary health care provider (physician/PA/NP)? _____

_____

☐ Yes ☐ No Any history of medical problems? Please explain: _____

_____

_____

☐ Yes ☐ No Any history of surgeries? Please explain: _____

_____

_____

☐ Yes ☐ No Have you ever been hospitalized? Please explain: _____

_____

_____

When was your last physical? _____

☐ Yes ☐ No Any known drug, environmental or food allergies? Please list: _____

_____

Date of last bowel movement? _____

If female, date of last menstrual period: _____ Age of first menses? _____

Are you on hormonal contraception (IUD, implant, other)? ☐ Yes ☐ No ☐ N/A

Do your periods occur monthly? ☐ Yes ☐ No If no, how often do they occur? _____

Have you experienced any of the following in the past 3 months? Check all that apply.

Medical

- ☐ Lightheadedness
- ☐ Dizziness/fainting
- ☐ Chest pain
- ☐ Sensitivity to cold
- ☐ Leg cramps
- ☐ Shortness of breath
- ☐ Irregular pulse
- ☐ Heart racing
- ☐ Neck/back pain
- ☐ Excessive sweating
- ☐ Blueness of lips/fingers
- ☐ Chronic pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel problems
- ☐ Stomach problems
- ☐ Trouble swallowing
- ☐ Appetite change
- ☐ Heartburn
- ☐ Cough
- ☐ Vomiting blood
- ☐ Dry mouth
- ☐ Visual disturbances
- ☐ Seizures

Mood

- ☐ Depressed mood/unhappy
- ☐ Little interest or pleasure in most activities
- ☐ Appetite or weight changes
- ☐ Trouble falling asleep
- ☐ Waking up in the middle of the night
- ☐ Sleeping too much
- ☐ Fatigue
- ☐ Feelings of worthlessness/guilt
- ☐ Problems concentrating
- ☐ Problems making decisions
- ☐ Thoughts of death
- ☐ Too much energy
- ☐ Impulsive behaviors
- ☐ Have gone days without sleeping

Anxiety

- ☐ Worry about a number of things
- ☐ Feel anxious majority of the time
- ☐ Difficult to control the worry
- ☐ Anxiety or fear in social situations
- ☐ Fear others are judging you
- ☐ Worry you will embarrass yourself
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Feeling restless
- ☐ Obsessive thinking
- ☐ Rituals to lower anxiety
- ☐ Nightmares
- ☐ Intrusive memories/ flashbacks
- ☐ Avoid people or places that bring up memories

General Life Concerns

- ☐ Financial problems
- ☐ Relationship/marital concerns
- ☐ Housing problems
- ☐ Problems completing daily tasks
- ☐ Hygiene issues
- ☐ Work concerns
- ☐ Legal issues

☐ Yes ☐ No Have you ever contemplated suicide in the past or ever engaged in any kind of self-harm behavior (suicide attempt or self-harm)? If yes, please describe:

☐ Yes ☐ No Have you ever talked with a psychologist, therapist, counselor, chaplain or other professional about emotional or personal concerns? If yes, please complete the following:

Reason for treatment | Setting (outpatient) | Dates | Who did you talk to?

☐ Yes ☐ No Have you ever been hospitalized for emotional problems or for substance abuse?

Reason for inpatient treatment | Dates | For how long? | Hospital name

Place an “X” in appropriate boxes to identify all illnesses/conditions in your blood relatives:

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Depression								
Anxiety								
Bipolar/manic depression								
Schizophrenia/psychosis								
Eating disorder								
Psychiatric hospitalization								
Alcohol/drug abuse								
Suicide/suicide attempt								

Where were you born? _____ Where did you grow up? _____

I have _____brothers and _____sisters. I was born (check one) ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ other _____

Parents are (check all that apply): ☐ Never married ☐ Still married ☐ Separated ☐ Divorced ☐ Unknown

If parents are divorced, how old were you? _____ Who raised you? _____

While you were growing up, during your first 18 years of life: (check one for each)

☐ Yes ☐ No Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?

☐ Yes ☐ No Did a parent or other adult in the household often or very often…Push, grab, slap or throw something at you? **or** Ever hit you so hard that you had marks or were injured?

☐ Yes ☐ No Did anyone ever…Touch or fondle you or have you touch their body in a sexual way? **or** Attempt or actually have oral, anal or vaginal intercourse with you?

☐ Yes ☐ No Did you often or very often feel that…No one in your family loved you or thought you were important or special? **or** Your family didn’t look out for each other, feel close to each other or support each other?

☐ Yes ☐ No Did you often or very often feel that…You didn’t have enough to eat, had to wear dirty clothes or had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☐ Yes ☐ No Were your parents separated or divorced?

☐ Yes ☐ No Was your mother or stepmother or a parent figure...Often or very often pushed, grabbed, slapped or had something thrown at her? **or** Sometimes, often or very often kicked, bitten, hit with a fist or hit with something hard? **or** Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

☐ Yes ☐ No Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

☐ Yes ☐ No Was a household member depressed or mentally ill or did a household member attempt suicide?

☐ Yes ☐ No Did a household member go to prison?

What is your highest level of education? _____

If you are in school, where do you go to school? _____

☐ Yes ☐ No Do you have any learning disabilities?

☐ Yes ☐ No Were you ever suspended or expelled from school?

☐ Yes ☐ No Have you ever served in the military?

What extracurricular activities are/were you involved with during school? _____

What activities or hobbies do you enjoy for fun or leisure time? _____

_____

_____

Are you currently facing, or do you have a history of legal problems? _____

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your service preferences:

_____

_____

Please indicate your ethnicity or cultural identification and their impact, if any, on your service preferences:

_____

Is there anything else you feel it is important for us to know right now? _____

_____

_____

_____

What do you want to achieve with eating disorder treatment? _____

_____

_____

_____

Signature of person filling out the form	Printed name	Date