Initial Intake & Assessment

Name _____
Date _____
Address_____
_____
City_____ State _____
Zip _____
Home Phone _____Work Phone _____
Email address _____
Date of Birth _____
Occupation _____
Your Pronouns (optional) _____
How did you hear about our
services?_____
Referred by _____
Reason for Referral _____

Have you ever worked with a dietitian? Yes ___ No ___
If yes, who/when/why?

Have you ever worked with a therapist? Yes ___ No ___
If yes, who/when/why?

Have you ever worked with a psychiatrist? Yes ___ No ___
If yes, who/when/why?

Are you currently under the care of a medical professional? Yes ___ No ___
Clinic/doctor's name _____

YOUR EMERGENCY CONTACT

Name_____Relationship_____
Phone number _____
Address _____

MEDICATIONS AND SUPPLEMENTS
List medications you are currently taking:
_____
_____
_____
_____

List vitamin/mineral supplements you are taking:
_____
_____
_____
_____
List herbal remedies you are taking:
_____

EATING PATTERNS

The following sections ask questions specific to your relationship with food, eating and your body.
Please complete to the best of your ability. You are always welcome to leave an answer blank if it
doesn't feel comfortable or safe to answer it now.

Describe what hunger feels like to you:
_____

Describe what fullness feels like to you:

_____

How do you decide what to eat?

_____

How do you know when to stop eating?

_____

Do you usually eat when you get hungry? Yes __ No __

Do you often eat when you are not hungry? Yes __ No __

Can you tell the difference between physical hunger and "emotional hunger"? Yes __ No __

What are your favorite foods?

_____

_____

_____

Have you ever been diagnosed with an eating disorder? Yes __ No __ If yes, please describe:

_____

_____

Circle any of the following that describes your eating patterns:

a) Eat 3 meals each day

b) Eat a 'normal' amount of food

c) Eat 3 meals with snacks

d) Restrict intake of food

e) Binge without purging

f) Binge followed by vomiting binging

g) Binge followed by restricting food intake

h) Binge followed by laxatives

i) Binge followed by diuretics

j) Binge followed by exercise

k) Vomit without binging

l) Restrict food intake without binging

m) Use laxatives without binging

n) Use diuretics without binging

o) Exercise excessively

p) Eat in secret

q) Eat in the middle of the night

r) Experience guilt after eating

MOVEMENT

Do you currently get regular physical activity? Yes ___ No ___ Describe:

Do you enjoy it?

Describe past history with exercise/movement:

Do you consider yourself a compulsive exerciser? (Is it hard not to exercise, even if you are tired, sick or not in the mood?) Yes ___ No ___

WEIGHT HISTORY

My treatment model is weight-inclusive, and your relationship with food and/or your body will be
the focus of our work. Understanding your unique body story includes getting a sense of your weight
history. Please answer as best you can. If you find any question triggering, you may leave it blank.

Do you know your current weight? If so, do you want to share it here?

_____

Has your weight changed significantly in the past 2-6 months? Yes ___ No ___ If yes, please describe:

_____

_____

Do you know your highest adult weight? _____ Age _____

Do you know your lowest adult weight? _____ Age _____

How often do you weigh yourself?

_____

What kind of fluctuations do you notice in your weight?

_____

_____

_____

What would you like to weigh? _____ Last time you weighed this? _____ For how long? _____

"Set point" is a weight where the body tends to stabilize with “normal eating.” What do you think your
"set point" weight is? _____ Last time you weighed this? _____ For how long? _____

What are three words you would use to describe how you feel in your body?

_____
_____

Circle the things you do to “check” your body:
Scrutinize myself in mirrors Measuring tape Picture collection
Compare my body to others Feeling for bones/fat Other
_____

MENSTRUAL PATTERNS: If you are a person who menstruates, please answer the next five questions.
Approximate date of last menstrual period
_____
What is your average weight fluctuation during your cycle?
_____

Age at first menses _____ Weight at first menses

_____

Do your cycles become irregular or cease with weight changes?

Yes ___ No ___

If yes, at what weight? _____

Are you on birth control pills or hormone replacement therapy?

Yes ___ No ___

GASTROINTESTINAL CONCERNS

Do you have problems with:

a) Constipation? Yes ___ No ___ Describe:

b) Diarrhea? Yes ___ No ___ Describe: _____

c) Nausea? Yes ___ No ___ Describe: _____

d) Bloated-ness? Yes ___ No ___ Describe: _____

OTHER HEALTH CONCERNS

List any medical conditions you would like me to be aware of:

_____

_____

_____

Are any of the following true for you (circle all that apply):

get cold easily bruise easily tired easily insomnia

hair falling out night sweats sudden hunger

LIFESTYLE/DAY TO DAY CARE:

What percentage of your day is focused on food and weight?

_____

What is your current stress level on a scale from 0-10, with 10 being high?

_____

What is your usual stress level?

_____

What causes you the most stress currently?

_____

What helps you cope with stress?

_____

_____

_____

How many hours do you usually work daily?

_____

How many hours do you sleep daily? _____

What do you do to relax?

_____

_____

_____

_____

How often do you drink alcohol? _____ How much per occasion?

_____

How often do you use recreational drugs? _____ Describe:

_____

ADVERSE LIFE EVENTS/TRAUMA

Many people experience adverse life events that impact their sense of well-being and safety, including and not limited to religious/spiritual trauma, oppression, bullying, harassment, abandonment, neglect, medical traumas, accidents, military service, historical trauma, and/or physical/emotional/sexual abuse or
assault. Over the course of your life, have you had any experiences that you would like me to know
about now?

_____

_____

_____

_____

_____

_____

Have you experienced weight-related discrimination or stigma from healthcare professionals, partners,
family members or in a workplace setting?

_____

_____

_____

_____

_____

What else would you like me to know about you?

_____

_____

_____

_____

_____

_____

What do you hope to achieve as a result of working with me?

_____

_____

_____

_____

_____

_____

_____