Eating Disorders Initial Assessment Intake Form

Personal Information

First Name

Last Name

Date of Birth

Age

Gender

Phone Number

Email Address

Address

Emergency Contact

Name

Relationship

Phone Number

Referral Information

Referred By

Reason for Referral

Presenting Concerns

Describe your current concerns with eating, weight, and shape

Eating Disorder Symptoms & History

How long have you been experiencing these concerns?

Have you been previously diagnosed with an eating disorder?

Please list any specific behaviors (e.g., restricting, binge eating, purging, over-exercising, laxative use)

Current Weight

Height

Highest Adult Weight

Lowest Adult Weight

Medical History

Current Medical Conditions

Current Medications

Allergies

Any hospitalizations related to eating disorder or other medical issues?

Mental Health History

History of any other mental health concerns?

Previous or current therapy/counseling?

Current Support System

History of self-harm or suicidal ideation?

Substance Use

Do you use alcohol, tobacco, or other substances?

Family History

Family history of eating disorders?

Family history of other mental health conditions?

Family history of medical conditions?

Additional Information

What are your goals for treatment?

Other information you'd like to share