CARRIE WATSON MSW, RSW

COUNSELLING • THERAPY • EATING DISORDERS TREATMENT

613.770.4587 • carrie@carriewatson.ca • 308 Wellington St., Kingston, ON

Intake – Long Form

Please complete this form as accurately as possible and return it prior to our first session. This information will help me prepare for our first meeting. You may leave questions you don't feel comfortable answering or write "NA" for any that do not apply to you. All information will be kept confidential.

Personal Information

Name: _____
Date: _____
Address: _____

Please list contact phone numbers and whether or not a message can be left at each number.
Home: _____ Messages? Y/N
Work: _____ Messages? Y/N
Cell: _____ Messages? Y/N

Emergency contact:_____ Contact's relationship to you: _____
Phone number: _____

Date of birth: _____ Referred by: _____
Family Physician: _____ Phone Number: _____
Date of last physical: _____ Any significant findings: _____
Are you seeing any other helping professionals (psychologist, psychiatrist, dietician, etc.)? Y/N
If Yes, please provide names and contact phone numbers: _____
_____
Are you receiving any other treatments (physiotherapy, chiropractic, naturopathic, etc)? Y/N

Significant Relationships

Are you in a committed partnership? Y/N
If Yes, do you live together? Y/N If Yes, for how long? _____
Partner's age: ____
Do you identify as: __ heterosexual __ homosexual __ bisexual __ other
Number of children: __ Ages of children: _____
Are you: __ separated __ divorced __ widowed
Date: _____
Please list the adults and children in your current living situation (include stepparents, common-law partners, roommates, etc): _____
_____

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Education

Highest level completed: __ high school __ college __ undergraduate __ graduate
Please list institutions for each certificate/diploma/degree: _____

_____

Are you currently a student? Y/N
If Yes, what school do you attend? _____
What program? _____

Employment

Are you currently employed? Y/N
If Yes, job title: _____ Number of hours worked per week? _____
Level of job satisfaction: __ high __ moderate __ low

Family

Please list all immediate family members (include parents, siblings, stepparents, stepsiblings, etc.), and each member's age: _____

_____

_____

_____

Do you have any deceased family members? Y/N
If Yes, which family member? _____ Year of passing: _____
Is your family close? Y/N
Please describe your relationship with your family: _____

_____

_____

Are your parents: __ married __ common-law __ divorced __ separated __ widowed
For how many years? _____
Has either parent remarried? Y/N If Yes, which parent(s)? _____
Mother's occupation: _____ Father's occupation: _____

Spirituality

Are you a religious or spiritual person? Y/N
If Yes, how do you express/practice your religion or spirituality? _____

_____

_____

_____

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Weight

Do you weigh yourself? Y/N
If Yes, how often? _____ Where? _____ When? _____
Current weight: _____ Height: _____
Desired weight: _____ Lowest weight? _____ When? _____
Is there a life event that caused this lowest weight? Y/N
If Yes, please explain: _____

_____

Do you have a history of weight fluctuations? Y/N
If Yes, why? _____
What do you think is your natural body weight (the weight you would be if you were not experiencing a poor relationship with food or your body or disordered eating)? _____
Described how satisfied or dissatisfied you feel with your body: _____

_____

Family Weight History

Describe your biological mother's weight: _____
Describe your biological father's weight: _____
Are any of your siblings over or underweight? Y/N
If Yes, please describe: _____
Is there a family history of dieting and/or a preoccupation with food/weight? Y/N
If Yes, please describe: _____

_____

Diet History

Have you ever dieted? Y/N
If Yes, how old were you? _____ What was your weight at that time? _____
Why did you begin the diet? _____
What diet did you follow? _____
Did the diet give you results? Y/N
If Yes, for how long? _____
Have you ever been involved with any dieting groups like Overeaters Anonymous or Weight Watchers? Y/N
What was the general attitude about bodies and food in your immediate family? _____

_____

Did your primary caregiver diet when you were young? Y/N

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Hunger

Please describe what physical hunger feels like in your body: _____

_____

Do you usually eat when you feel hungry? Y/N

If No, what do you do instead of eating? _____

Circle the times at which you most typically eat:

6am 7 8 9 10 11 12 noon 1pm 2 3 4 5 6 7 8 9 10 11 12 midnight

Record a sample of your food intake for a typical day:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

What food(s) do you like to eat? _____

What food(s) do you avoid? _____

Are you a vegetarian? Y/N

If Yes, how do you get protein in your daily food intake? _____

How much water/clear fluids do you drink in a typical day? _____

How much caffeine to you drink in a typical day? _____

How comfortable are you with your current food behaviours? __ extremely comfortable

__ very comfortable __ uncomfortable __ very uncomfortable __ extremely uncomfortable

Binge Eating

Do you experience periods in which you eat uncontrollably? Y/N

If Yes, how often? Per day: __ Per week: __ Per month: __

When do you usually binge eat? _____

Where? _____ Age at which binge eating began: _____

How did you start binge eating? _____

_____

Purging

Do you make yourself vomit? Y/N

If Yes, how often? Per day: __ Per week: __ Per month: __

When do you usually purge? _____

Where? _____ Age at which purging began: _____

How did you start purging? _____

_____

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Other Weight Control

Do you go for long periods without eating? Y/N
If Yes, for how long will you not eat? Hours: __ Days: __
What other things do you do to try to control your weight? _____
_____

Exercise

How often do you exercise? Times per day: __ Times per week: __
How long do you spend exercising each time? _____
What type of exercise do you do? _____
Have you ever participated in an intramural, varsity, Olympic, or professional sport? Y/N
If Yes, what sport? _____ At what ages? _____
Reason for stopping? _____

Symptoms

Please check symptoms felt since the development of your eating problems:

__ sore throat	__ feeling tired/weak	__ feeling bloated	__ constipation
__ stomach pains	__ feeling cold	__ swollen glands	__ dizziness
__ sore joints	__ water retention	__ hair loss	__ hair growth
__ dental problems	__ muscle spasms/cramps	__ depression/irritability	__ anxiety
__ over sensitivity to noise/touch/light		__ other (please explain): _____	

Females

Have you ever missed a period for 3 consecutive months for reasons other than pregnancy? Y/N
If Yes, when did your periods cease? _____ Have they returned regularly? Y/N
If Yes, when? _____
Are you taking birth control pills? Y/N
Have you had a bone density test? Y/N
If Yes, when? _____ What were the results? _____
Have you ever been pregnant? Y/N
If Yes, how many: __ live births __ miscarriages
__ stillbirths __ abortions
Highest weight gain in pregnancy: _____ Lowest weight gain in pregnancy: _____

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Sexual History

Have you ever engaged in sexual intercourse? Y/N
Has anyone ever touched you in a way that felt uncomfortable, or forced you to participate in a sexual act against your will? Y/N

Sleep Patterns

How many hours do you sleep per night: _____
Do you have difficulty falling asleep? Y/N
Do you have difficulty staying asleep? Y/N

Habits

Do you engage in or use any of the following:

__ cigarettes/tobacco __ coffee __ alcohol __ sleeping pills
__ diet pills __ recreational drugs __ steroid use __ laxative use
__ body harm (cutting, burning, self mutilation)

Mental Health

Are you currently experiencing any mental health issues? Y/N
If Yes, please describe (depression, anxiety, OCD, PTSD, bipolar disorder, etc): _____

_____

_____

Are you currently having thoughts about suicide? Y/N
Have you ever experienced any mental health issues? Y/N
If Yes, please describe (depression, anxiety, OCD, PTSD, bipolar disorder, etc): _____

_____

_____

Have you ever had thoughts about suicide? Y/N
Have you ever made a suicide attempt? Y/N
If Yes, when? _____

Medications

Do you take any medications? Y/N
If Yes, please list medication, dosage, and reason: _____

_____

_____

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Therapy/Counselling History

Are you currently in therapy/counselling? Y/N
If Yes, name of therapist: _____ Presenting problem: _____
Have you been in therapy/counselling in the past? Y/N
If Yes, name of therapist: _____ Presenting problem: _____
Have you ever been hospitalized for eating related issues? Y/N
If Yes, when? _____ Where? _____ Duration? _____

Other

What interests, hobbies, social activities and sports did you have or participate in before your issues with eating developed? _____

What interests, hobbies, social activities and sports do you have or participate in now? _____

Please describe some of the positive qualities about yourself that would be helpful to know in order to most effectively help you: _____

Who are your major supporters and where do they live? _____

Do your supports know about your eating issues? _____

Expectations From Counselling

What are your goals for working with me? _____

What would you like to learn? _____

How ready do you feel to let go of the thoughts/behaviours associated with the disordered eating? __ not at all ready __ slightly ready __ ready __very ready

How willing would you be to gain 5-10 pounds if you knew the behaviours/thoughts would diminish? __ not at all willing __ slightly willing __ willing __ very willing

Please list the thoughts/behaviours you would like to change: _____

Please include any other information you feel would be useful for me to know about you to better provide the support that you need (use back of page if needed): _____