carolina house

Confidential Intake Application Form

In order for us to know you better and create the most appropriate treatment recommendations, please fill out this questionnaire completely.

Name: _____ DOB: _____

Age: _____ Marital Status: ☐ Married/Partnered ☐ Single ☐ Divorced ☐ Widowed

SS#: _____ Home Phone Number: _____ Mobile Phone Number: _____

Mailing Address: _____

Email address: _____ Highest Level of Education: _____

Occupation: _____ Place of employment: _____

Race: _____ Ethnicity: _____ Sexual Orientation: _____ Gender Expression: _____

Preferred Pronouns: _____ Religious Preference: _____

Are you able to: Speak fluently in English? ⊙ Y ○ N Read fluently in English? ⊙ Y ○ N

Name of Primary Support Person/Emergency Contact: _____ Relationship: _____

Primary Support Person/Emergency Contact Address: _____

Primary Support Person/Emergency Contact Phone Number: _____

How did you hear about us? _____

1. Why have you contacted us? _____
2. How long have you had problems with food/eating disorder symptoms? _____
3. Have there been periods of recovery during that time?_____
4. How motivated are you personally for treatment at this time (using a scale of 1-10 with 10 being extremely motivated)? ___
5. How much do you fear gaining weight?

   ☐ Extremely Afraid ☐ Slightly Afraid ☐ Very Much Afraid ☐ Moderately Afraid ☐ Not at all Afraid

   Explain: _____
   _____

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6. Does your body size or shape disturb you?
   ☐Extremely ☐Slightly ☐ Very Much ☐ Not at All ☐ Moderately
7. Height: ___ ft ___in
8. Current Weight: _____
   Highest Weight (not including any pregnancies): _____ Date: _____
   Lowest weight: _____ Date: _____
   Weight 2 years ago: _____ 1 year ago: _____ 6 months ago: _____

Eating Disorder Behaviors:

****For the following section(s), please indicate your behaviors for the last 30 days or, if you're currently in treatment, your behaviors prior to entering treatment.****

9. How many days per week do you restrict your food on average?

   Select One -**AND**- How long have you been actively restricting your food? _____

   Describe how you restrict your food (i.e. counting calories, eating only certain foods, fasting, etc.) If you do restrict calories, please indicate how many calories you limit yourself to each day:

   _____

   _____

10. On average, how many days per week do you purge (i.e. vomiting, laxatives, diuretics, etc.) your food?

    Select One -**AND**- How long have you been actively purging your food? _____

    Check all that apply: Do you purge by vomiting ☐ laxative use ☐ diuretic use ☐ enema use ☐ or diet pills? ☐
    If yes, how many times per week do you purge your food? _____

    Describe a typical episode of purging:_____

    _____

11. During the last 30 days, how many days per week do you binge on average?

    Select One –**AND**- How long have you been actively bingeing? _____

    Describe a typical episode of bingeing (please include time(s) of day you typically binge, foods typically binged on, and approximate number of calories): _____

    _____

12. During the last 30 days, how many days per week on average do you exercise (for any length of time, including any sports practice or consistent body movement that you might do for your employment)?

    Select One -**AND**- On average, how many hours per day do you exercise? _____

    Describe a typical exercise pattern for you:

    _____

    _____

    Do you feel you exercise for enjoyment or to compensate for food consumed?

    _____

    _____

13. Have you ever had other problems with eating or attempts to control your eating, which has not been covered adequately so far (i.e. spitting out food, stomach stapling, jaw wiring, intestinal bypass, substance abuse, regurgitation)? ☐ Yes ☐ No
    If yes, explain: _____

Safety and Risks:

14. Are you currently having suicidal thoughts?
    ☐ No ☐ Yes, Passive (i.e.; "It would be easier if I weren't alive")
    If passive, please explain: _____

    _____

    ☐ Yes, Active (i.e., "I am having thoughts about ending my life")
    If active, what is the plan, intent or means? _____

    _____

15. Have you been suicidal in the past? ☐ Yes ☐ No
    If yes, how many times? _____ When? _____
    If so, by what means? _____

16. Are you currently engaging in self-harm behaviors (i.e. burning, cutting, hitting)? ☐ Yes ☐ No

If yes, how many days per week, on average, are you engaging in self-harm behaviors?

Select One –**AND**- How many months have you been actively self-harming? _____

Describe a typical episode of self-harm (what you use to self-harm, where you typically self-harm on your body):

_____

_____

Are you able to commit to safety while at Carolina House? ☐ Yes ☐ No

17. Do you ever exhibit periods of anger/rage/aggression? ☐ Yes ☐ No
If yes, explain (i.e. verbal, physical): _____

_____

Substance Abuse History: (check items that are applicable)

	Daily (amount)	Weekly (amount)	Monthly (amount)	Last Used
Marijuana				
Cocaine/Crack				
Speed				
Barbiturates				
Heroin				
PCP				
Hallucinogens				
Tranquilizers				
Antidepressants				
Alcohol				
Valium				
Cigarettes				
Other				

******Please note that Carolina House is a non-smoking facility******

Food and Nutrition:

18. Do you have any food allergies/intolerances? If so, to what and what is the reaction?

_____

19. When was the last reaction, How often do you experience allergy symptoms? _____

_____

20. What treatment did you receive, and how long did the symptoms last? Was use of the epipen required?_____

_____

21. Have you been evaluated by an allergy specialist or had any testing done? If so, please provide documentation. (Medical documentation of IGE testing will be required)_____
22. Do you have any food restrictions that you observe as part of your religion? If so, what are the restrictions? _____

_____

23. Do you eat any non-food substances? If so, what?

_____

Medical History:

24. Do you require any assistive devices (i.e., wheelchair, hearing aids, etc.)? ☐ Yes ☐ No
If so please explain:_____
25. Are you currently taking any medication? ☐ Yes ☐ No
If yes, please list: *(please attach list if more room is needed)*

Name of Medicine	Dose	Frequency	Name of Medicine	Dose	Frequency

26. How has your eating disorder affected you medically (i.e. loss of menstrual periods, bone loss, heart palpitations, etc.)?
_____
_____

27. Do you suffer from chronic pain? ☐ Yes ☐ No; If yes, how often does your pain interfere with your ability to perform daily activities? _____
_____

28. Have you ever sought treatment from a pain clinic or pain specialist to treat your pain? If yes, please provide the dates of treatment and the most current treatment plan. _____
_____

29. What medications do you use for your pain? Please provide the name, dose, and how often you take the medication(s).
_____

30. Is there anything we haven't asked that you believe we need to know in assisting you with the most appropriate treatment recommendations?_____
_____