Healthy Lifestyles

Name_____

Client Information

Please complete the following information and bring to your first session. If you are unsure about how to answer any of the questions, please leave them blank to discuss in the session.

Name: _____ Date of Birth: _____

Address: _____

Tel:(H)_____ Tel:(W)_____ Tel:(C)_____

Email Address: _____

May I contact you by: 1. Phone (Y/N) 2. Address (Y/N) 3. Email (Y/N)

Name of Professional/Resource who referred you: _____

How would you describe your current problem?

_____

_____

What are your goals for treatment?

_____

_____

Medical History

Other Medical Problems	Treatments/Medications/Supplements
1._____	1._____
2._____	2._____
3._____	3._____

Food Allergies/Intolerances: List any food allergies you may have:

_____

_____

Please provide names and contact numbers of other physicians or therapists involved in your healthcare:

1._____

2._____

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Name_____

Date of Last Physical_____ Date of Last Lab Report_____

Family History

Relative	Name	Age (Current or at death	Illnesses or cause of death	History of Substance Abuse (SA) or Mental Illness (MI)
Spouse/Partner				
Child				
Child				
Child				
Father				
Mother				
Stepparents				
Grandparents (M)				
(M)				
(P)				
(P)				
Uncles/Aunts				
Brothers/Sisters				

Family Relationships: (Describe the following relationships)

Your parents' relationship with each other:

(Past)_____

(Present)_____

Your parents' relationship with you:

(Past)_____

(Present)_____

Your parents' relationship with your siblings:

(Past)_____

(Present)_____

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Your parents' relationship with other family members:

(Past)_____

(Present)_____

Your relationship with your siblings:

(Past)_____

(Present)_____

Your siblings' relationships with each other:

(Past)_____

(Present)_____

Your relationship with your current spouse/partner:

_____

_____

Your relationships with ex-spouses/partners: (How long was the relationship and why it ended)

_____

_____

Your relationship with your children: (List biological, adopted, stepchildren)

_____

_____

_____

Abuse History:

Please describe any incidences where were abused: (Indicate by whom, when, where and how long)

- Physical abuse_____
  _____
- Sexual abuse_____
  _____
- Neglect_____
  _____
- Emotional abuse_____
  _____

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Substance Abuse History

Cigarettes: Y/N Packs per day/Frequency_____

Alcohol: Y/N Type/Frequency_____

Drugs Y/N Type/Frequency_____

Please list any treatment you have received for substance abuse in the past. Please indicate where and when. _____

_____

_____

Mental Health History

Have you ever received medicine or counseling services/long term treatment for emotional or psychiatric problems before? (If so, provide details about when and facility.)

_____

_____

_____

Education and Employment History

Education/Degree	Institution	Dates Attended	Completion Y/N

Is there a history of a learning disability?

_____

Employment/Job Title	Company	Dates Employed	Reason for Leaving

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Legal History: (List any history of involvement with the police or judicial system)

_____

_____

Military History: (Describe any training or service in the military)

_____

_____

Religious Affiliations: (Describe the role your spirituality plays in your life)

_____

_____

Immigration History: (If applicable, describe when, where from and under what conditions you immigrated to the United States. How have you/your family adjusted to the change?)

_____

Eating Behaviors:

PAST

When was the first time you binged? How old were you?

_____

Where were you during that first binge?

_____

What did you eat during that first binge?

_____

Were you aware of how much you were eating?

_____

What was the trigger to the first binge?

_____

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How frequent were your binges when you first started?

_____

How old were you at your highest frequency of binging?

_____

Did you live with a family member who was constantly dieting and/or unhappy with their weight?

_____

Did you live with family members or friends who practiced an eating disorder? If so, who and how long?

_____

What comments were made about your weight and eating habits by family members, friends, coaches etc?

_____

Did you struggle with anorexia and or bulimia in the past?

_____

Were you abusing drugs/alcohol/nicotine during your binges?

_____

What has been your highest frequency of binging? (Times per day/week/month)

_____

What were your triggers at the time?

- ☐ I don't know
- ☐ I know _____

Age/Date Problems Began	Behavior/Treatment	Weight Change

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PRESENT

When was your last binge?

_____

How frequently are you binging at the present time?

_____

Highest frequency_____

Lowest frequency_____

What are the triggers?

_____

_____

Do you binge eat when: (check all that apply)

- ☐ Depressed/anxious/emotional
- ☐ Stressed
- ☐ Needing comfort
- ☐ Blood sugars are low
- ☐ Tired

Dietary Habits: (Frequency per day/week/month)

- How often do you diet/fast/use diet pills or cut back the amount of food you eat? _____
- How often do you feel out of control eating large quantities of food? List foods: _____

  _____

  _____

  How often do you feel the need to remove food by vomiting after eating or binging? _____
- How often do you exercise? _____
- How often do you feel the need to exercise immediately after eating? _____
- How often do you use laxatives/diuretics after eating? How many? _____
- What percentage of your time do you spend thinking about food? _____
- How often do you wake up dreaming about food? _____
- How often do you crave specific foods? List foods:

  _____

  _____
- How often do you eat when you are sad, bored, nervous or angry? _____
- How often do you look in the mirror and dislike your body? _____
- How often do you weigh yourself? _____
- How often does your weight affect your mood? _____
- How often do you eat when you are hungry and stop when you are full? _____

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- How often does your work/school schedule affect how you eat? _____
- How often do you feel guilty about eating? _____
- How often is your eating affected by friends and family members' comments? _____
- How often do you chew gum/eat candy? _____
- How often do you drink tea, coffee and/or soda? _____
- How often do you smoke? _____

FUTURE

What do you want your relationship to be like with food, weight and eating in the future?

_____

_____

_____

What is the purpose behind the changes you want to make?

_____

_____

_____

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