CARRIE WATSON MSW, RSW

COUNSELLING • THERAPY • EATING DISORDERS TREATMENT

(613) 770-4587 • carrie@carriewatson.ca • 425 Bagot St., Unit 1, Kingston, ON

Intake – Short Form

Please complete this form as accurately as possible and bring it with you 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

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)? _____

Weight

Do you weigh yourself? Y/N
If Yes, how often? _____ Where? _____ When? _____
Current weight: _____ Height: _____
Desired weight: _____ Lowest weight? _____ When? _____
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: _____

_____

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Binge Eating

Do you experience periods in which you eat uncontrollably? Y/N
If Yes, how often? Per day: __ Per week: __ Per month: __
How did you start binge eating? _____

_____

Purging

Do you make yourself vomit? Y/N
If Yes, how often? Per day: __ Per week: __ Per month: __
How did you start purging? _____

_____

Exercise

How often do you exercise? Times per day: __ Times per week: __
Have you ever participated in an intramural, varsity, Olympic, or professional sport? Y/N

Symptoms

__ 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): _____	

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

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)			

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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

Expectations From Counselling

What are your goals for working with me? _____

_____

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 include any other information you feel would be useful for me to know about you to better provide the support that you need: _____

_____

_____

_____

_____

_____

_____