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Intake Questionnaire

Name: ________
Birthdate: ________
Date: ________

Please tell us a little about why you are seeking treatment at this time: ________

Are you currently working with any Outside Treatment Providers? If yes, please list contact information below for each provider.

Physician: ________
Address: ________
Phone number: ________
How long have you been working with him/her? ________
How often do you see this provider (per month, week, etc.)? ________

Therapist: ________
Address: ________
Phone number: ________
How long have you been working with him/her? ________
How often do you see this provider (per month, week, etc.)? ________

Additional Therapist: ________
Address: ________
Phone number: ________
How long have you been working with him/her? ________
How often do you see this provider (per month, week, etc.)? ________

Psychiatrist: ________
Address: ________
Phone number: ________
How long have you been working with him/her? ________
How often do you see this provider (per month, week, etc.)? ________

Dietitian: ________
Address: ________
Phone number: ________
How long have you been working with him/her? ________
How often do you see this provider (per month, week, etc.)? ________

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Do you have additional Treatment History including facilities or hospitalizations? If yes, please list facility below and include the reason for the admission.

Inpatient: ________
Residential: ________
PHP: ________
IOP: ________

Are you on any current medications? Please list all medications including over-the counter medications.

Name of medication	Dosage	Frequency	Prescribing physician	Length of time taken

Height: ________ Weight: ________

What eating related symptoms are you CURRENTLY struggling with?

Restricting: ________
Bingeing: ________
Purging: ________
Exercise: ________
Food Allergies: ________
Other: ________

Please indicate if you have ever been diagnosed or are struggling with any of the following co-occurring conditions.

Depression	
Bipolar Disorder/Mania/Hypomania	
Anxiety	
Panic Disorder	
Social Phobia	
ADHD	
Obsessive Compulsive Disorder	
Substance Abuse	
Alcohol Abuse	
Other Impulse Disorders (shoplifting, sexual compulsivity, gambling)	
Other	

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Do you ever have suicidal thoughts? ________

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Have you ever tried to commit suicide? ________
If yes, how and when: ________

Do you engage in self-harm behaviors? ________
If yes, where on your body: ________

Can you commit to safety while in treatment? ________

What factors are motivating you for treatment at this time? ________

Thank you. Please email this form to admissions@montenido.com. We look forward to supporting you on your healing journey.