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NOVI INTERNAL MEDICINE AND PEDIATRICS
NEW PATIENT INTAKE FORM
Dr. Carrie Leff

NAME	
AGE	
PHONE NUMBER FOR PARENT	
PHONE NUMBER FOR PATIENT	
EMAIL (PARENT)	
EMAIL (PATIENT)	

If you are a student:

What school do you attend?	
What grade are you in?	
What are your grades typically?	
Are you involved in activities outside of school (please list)?	
Are you having issues with drama with friends at school?	
What are your strengths?	

Home Life:

Are you parents married?	
Who do you live with?	
Do you have siblings (list sex and ages)?	
Where are you in the birth order?	
How would you describe your relationship with your siblings?	
How would you describe your relationship with your parents?	

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EATING DISORDER (ED) HISTORY:

When was the first time you began to struggle with eating or weight?	
Do you have issues with your mood?	
What was your lowest weight since age 13?	
What was your highest weight since age 13?	
When were you happiest with your weight?	
Do you have anxiety around food/eating?	

Please list ALL treatment facilities/doctors/therapists that have treated you for your ED:

NAME	DATES OF TREATMENT	LOCATION	DESCRIPTION OF SERVICES:

PATIENT NAME: DOB:

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Please check all that apply to you:

I DO:

▢ restrict of calories/food	▢ over exercise	▢ purge	▢ have food/eating rituals
▢ binge eat	▢ check my appearance often	▢ think about my weight compared to others	▢ feel fat
▢ use laxatives	▢ avoid certain foods	▢ think about food/weight obsessively	▢ feel guilty after eating
▢ count calories	▢ know that others worry about my weight	▢ desire to be thinner	▢

Do you think you have an eating disorder now?	▢ yes definitely	▢maybe/sort of	▢ not sure	▢ I did in the past, but do NOT now	▢ no, I do not have an eating disorder	▢ other:
How strongly do you believe you need treatment now?	▢ positive I need it	▢ sort of sure that I need it	▢ not sure	▢ somewhat sure I do NOT need it	▢ positive I do NOT need it	▢ other:

PLEASE INCLUDE ANY OTHER INFORMATION THAT MAY BE RELATED TO YOUR VISIT:

PATIENT NAME: DOB:

Eating Attitudes Test© (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date Month: .... Day: .... Year: .... 2) Gender: ❑ Male ❑ Female

3) Height Feet: .... Inches: ....

4) Current Weight (lbs.): .... 5) Highest Weight (excluding pregnancy): ....

6) Lowest Adult Weight: .... 7) Ideal Weight: ....

	Part B: Please check a response for each of the following statements:	**Always**	**Usually**	**Often**	**Sometimes**	**Rarely**	**Never**
1.	Am terrified about being overweight.	❑	❑	❑	❑	❑	❑
2.	Avoid eating when I am hungry.	❑	❑	❑	❑	❑	❑
3.	Find myself preoccupied with food.	❑	❑	❑	❑	❑	❑
4.	Have gone on eating binges where I feel that I may not be able to stop.	❑	❑	❑	❑	❑	❑
5.	Cut my food into small pieces.	❑	❑	❑	❑	❑	❑
6.	Aware of the calorie content of foods that I eat.	❑	❑	❑	❑	❑	❑
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	❑	❑	❑	❑	❑	❑
8.	Feel that others would prefer if I ate more.	❑	❑	❑	❑	❑	❑
9.	Vomit after I have eaten.	❑	❑	❑	❑	❑	❑
10.	Feel extremely guilty after eating.	❑	❑	❑	❑	❑	❑
11.	Am preoccupied with a desire to be thinner.	❑	❑	❑	❑	❑	❑
12.	Think about burning up calories when I exercise.	❑	❑	❑	❑	❑	❑
13.	Other people think that I am too thin.	❑	❑	❑	❑	❑	❑
14.	Am preoccupied with the thought of having fat on my body.	❑	❑	❑	❑	❑	❑
15.	Take longer than others to eat my meals.	❑	❑	❑	❑	❑	❑
16.	Avoid foods with sugar in them.	❑	❑	❑	❑	❑	❑
17.	Eat diet foods.	❑	❑	❑	❑	❑	❑
18.	Feel that food controls my life.	❑	❑	❑	❑	❑	❑
19.	Display self-control around food.	❑	❑	❑	❑	❑	❑
20.	Feel that others pressure me to eat.	❑	❑	❑	❑	❑	❑
21.	Give too much time and thought to food.	❑	❑	❑	❑	❑	❑
22.	Feel uncomfortable after eating sweets.	❑	❑	❑	❑	❑	❑
23.	Engage in dieting behavior.	❑	❑	❑	❑	❑	❑
24.	Like my stomach to be empty.	❑	❑	❑	❑	❑	❑
25.	Have the impulse to vomit after meals.	❑	❑	❑	❑	❑	❑
26.	Enjoy trying new rich foods.	❑	❑	❑	❑	❑	❑

	Part C: Behavioral Questions. In the past 6 months have you:	**Never**	**Once a month or less**	**2-3 times a month**	**Once a week**	**2-6 times a week**	**Once a day or more**
A.	Gone on eating binges where you feel that you may not be able to stop?	❑	❑	❑	❑	❑	❑
B.	Ever made yourself sick (vomited) to control your weight or shape?	❑	❑	❑	❑	❑	❑
C.	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	❑	❑	❑	❑	❑	❑
D.	Exercised more than 60 minutes a day to lose or to control your weight?	❑	❑	❑	❑	❑	❑
E.	Lost 20 pounds or more in the past 6 months		❑ Yes			❑ No	

• Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.

EAT-26: Garner et al. 1982, Psychological Medicine, 12, (871 878); adapted/reproduced by D. Garner with permission.