Cambridge Eating Disorder Center

Transitional Living Intake Questionnaire

Name:
Please outline reasons why you are applying to CEDC's Transitional Living Program:
Please tell us about your current living situation:
What do you like *most* about your current living situation?
What do you like *least* about your current living situation?

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How do you plan to finance your stay in transitional living?
Please tell us about your current support system:
What are your personal strengths?
What are your goals for the coming year?
What are your expectations in terms of apartment-mates?

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We require that each resident has a minimum of 30 hours of structured, day-time activity per week. Please indicate the activities you will complete to meet this requirement:

DAY TREATMENT/INTENSIVE OUTPATIENT PROGRAM
Name of Program:
Start Date:
Number of Hours Spent in Program:

PAID EMPLOYMENT
Position Title:
Employer:
Start Date:
Number of Hours per Week:
Schedule:

VOLUNTEER WORK
Position Title:
Location of Volunteer Opportunity:
Start Date:
Schedule:

COLLEGE/CLASSES
Location:
Start Date:
Schedule:

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Education and Employment History:
Highest Grade Completed:
Do you plan to take any classes while in transitional living?
Do you need help with pursuing an education related activity?
Do you need help pursuing an employment opportunity?

Family Information:		
Parent 1- Name:	Age:	Phone:
Parent 2 - Name:	Age:	Phone:
Sibling 1- Name:	Age:	Phone:
Sibling 2- Name:	Age:	Phone:
Sibling 3- Name:	Age:	Phone:
Sibling 4- Name:	Age:	Phone:
Does anyone in your family struggle with disordered eating, substance abuse or a psychiatric condition? If so, please explain:		

Medical History:
Date of Last Physical Exam:
Date of Last Menstrual Period:
Describe Any Current Medical Problems:

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Please List Any Known Allergies:

Please List Any Medical Hospitalizations and Reasons for Hospitalizations:

Please List Current Medications for Medical Problems Described Above:

Medication Information:

PLEASE LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING

Medication Name:	**Dosage:**	**Prescribing Physician:**

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Psychiatric Treatment History: PLEASE LIST DETAILS OF TREATMENT YOU HAVE RECEIVED FOR THE FOLLOWING:
Inpatient Psychiatric:
Residential:
Partial Hospital:
Intensive Outpatient:
Outpatient Therapy:
Inpatient Medical for Eating Disorders:
Emergency Room Visits:

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Trauma History Questions	**Yes**	**No**
Have you ever experienced physical abuse?	☐	☐
Have you ever experienced sexual trauma?	☐	☐
Have you ever experienced emotional abuse?	☐	☐

Psychological Conditions:

HAVE YOU EVER BEEN DIAGNOSED/STRUGGLED WITH ANY OF THE FOLLOWING CONDITIONS?

	Yes	**No**
Substance Abuse	☐	☐
Alcohol Abuse	☐	☐
Clinical Depression	☐	☐
Bipolar Disorder	☐	☐
Anxiety Disorder	☐	☐
Panic Attacks	☐	☐
Social Anxiety	☐	☐
Obsessive-Compulsive Disorder	☐	☐
Impulsive Disorder (shopping, gambling, sexual impulsivity, stealing)	☐	☐
Self-harming (cutting, burning, scratching, hitting, biting)	☐	☐
Delusions or Hallucinations	☐	☐
Attention Deficit Disorder	☐	☐

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Please answer the questions below:

Do you have a history of suicide attempts? If yes, please detail below when and how:
Do you currently have any suicidal thoughts?
How do you deal with feelings of frustration and anger?
How do you deal with feelings of depression?

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Have you ever had any legal issues? If so, please explain:

Eating and Weight:

PLEASE PROVIDE THE REQUESTED INFORMATION BELOW

Current Weight:	Height:
Desired Weight:	Weight Before Onset of Eating Disorder:
	Age at Onset of Eating Disorder:
Highest Weight (at Current Height):	Lowest Weight (at Current Height):

Do you restrict your food intake? If yes, how do you restrict (e.g. reducing calories, fasting, certain food avoidance, fluid restriction, etc.)

Do you binge eat? If yes, how often?

When?

What foods do you binge on?

Do you induce vomiting? If yes, how often?   **When? (e.g., after meals, after any eating, after binge eating, etc.)**
Do you use laxatives? If yes, what type?   **How many?**   **How often?**
Do you use diet pills? If yes, what type?   **How many?**   **How often?**

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Do you use diuretics? If yes, what type? **How many?** **How often?**
Do you exercise? If yes, what activities? **How often?** **For how long?**
Please share information about any food or eating rituals that you have:

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Other relevant information: PLEASE TELL US ABOUT ANY OTHER ADDITIONAL INFORAMTION THAT WOULD BE IMPORTANT FOR US TO KNOW ABOUT YOU:

______________________________ Signature

______________________ Date

Please fax this completed form to (617) 547-0003