Walden Living

Intake Questionnaire

Contact Information

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

Phone: (H) _____ Ok to leave VM: Y / N (C) _____ VM: Y / N TEXT: Y / N

Email: _____

Current Treatment Team

Type of Provider(s) Name(s) of Facility/Provider Contact Information

_____

_____

_____

Treatment History

Type of Treatment	Name(s) of Facility/ Provider	Dates and Duration
Inpatient Treatment		
Residential Treatment		
Partial Treatment		
Intensive Outpatient Program		
Outpatient Care		
Medical		
Other		

Current Diagnosis (circle all that apply)

Anorexia Nervosa	Primary	Secondary	N/A
Bulimia Nervosa	Primary	Secondary	N/A
Eating Disorder NOS	Primary	Secondary	N/A
Binge Eating Disorder	Primary	Secondary	N/A
Obsessive Compulsive Disorder	Primary	Secondary	N/A
Social Phobia (Anxiety)	Primary	Secondary	N/A
Other Anxiety Disorder _____	Primary	Secondary	N/A
Depression	Primary	Secondary	N/A
PTSD	Primary	Secondary	N/A
Bipolar Disorder	Primary	Secondary	N/A
Alcohol Abuse	Primary	Secondary	N/A
Substance Abuse/Chemical Dependency	Primary	Secondary	N/A
ADD/ADHD	Primary	Secondary	N/A
Other Impulsive Disorder (Shopping/Gambling)	Primary	Secondary	N/A

Eating Disorder Symptoms

Do you restrict your food intake?

□ No □ Yes, but only in the past (When did you stop?)_____ □ Yes, I currently restrict

If yes, how do you restrict (Fasting, Specific food avoidance, Caloric) _____

Do you binge eat?

□ No □ Yes, but only in the past (When did you stop?)_____ □ Yes, I currently binge

If yes, how often do you/did you binge per day/week on average? _____

What are you preferred bingeing foods? _____

Do you purge?

□ No □ Yes, but only in the past (When did you stop?)_____ □ Yes, I currently purge

If yes, how often do you/did you purge per day/week on average? _____

Do you use any other forms of compensatory behavior (e.g. Diet pills, Laxatives, Diuretics, Enemas)?

□ No □ Yes, but only in the past (When did you stop?)_____ □ Yes, I currently use other forms

If yes, how often and what forms of compensatory behavior do you/did you use? _____

_____

Anxiety Symptoms

Do you engage in unwanted ritualistic behaviors that are not related to food, weight or shape?

□ No □ Yes, but only in the past (When did it stop?)_____ □ Yes, I currently engage in behaviors

If yes, please explain symptom presentation. _____

_____

Do you experience unwanted ritualistic thoughts that are not related to food, weight or shape?

□ No □ Yes, but only in the past (When did it stop?)_____ □ Yes, I currently experience these thoughts

If yes, please explain symptom presentation. _____

Depression

Are your depression symptoms currently impacting on your quality of life?

□ No □ Yes If yes, please explain: _____

Do you need help with the ability to enjoy activities that you used to enjoy?

□ No □ Yes If yes, please explain: _____

Do you have problems with self- esteem and/ or relationships as a result of depression?

□ No □ Yes If yes, please explain: _____

Do you have problems with energy, sleep or appetite as a result of depression?

□ No □ Yes If yes, please explain: _____

AODA Symptoms

Do you drink alcohol?

☐ No ☐Yes, but only in the past (When did you stop?)_____ ☐ Yes, I drink alcohol

If yes, how often (times per week) and how much do you/did you drink? _____

Do you use illegal substances?

☐ No ☐Yes, but only in the past (When did you stop?)_____ ☐Yes, I use illegal substances

If yes, what forms, how often, and how much do you/did you use? _____

Do you abuse prescription drugs?

☐ No ☐ Yes, but only in the past (When did you stop?)_____ ☐ Yes, I abuse prescription drugs

If yes, how do/did you abuse prescription drugs? _____

Have you ever been in treatment for substance abuse? ☐ No ☐ Yes

If Yes, When and Where _____

_____

Physical Safety Concerns

Do you have concerns about suicidal ideation?

☐ No ☐Yes, but only in the past ☐Yes, I currently struggle with suicidal ideation

If yes, please explain. _____

Do you have concerns about self-harm?

☐No ☐Yes, but only in the past ☐Yes, I currently struggle with self-harm

If yes, please explain_____

Legal History

Have you ever experienced any legal problems? ☐ No ☐ Yes

If yes, please explain. _____

_____

Family History

Please circle the conditions for which you have a family history.

Eating Disorder	PTSD	Excessive internet use/video game	
Depression	Other Impulsive Disorder	Alcohol Abuse	Substance Abuse
Anxiety	OCD	ADD/ADHD	
Social Phobia	Bipolar	Other Medical Condition:_____	

Getting to Know You

Who is in your support network? _____

How do they support you? _____

Tell us about your relationship with your family: _____

_____

Would anyone else be involved with your stay at Walden Living? _____

Do you utilize any other resources for support? (spiritual/art/etc.) _____

Do you have any interests or hobbies you would like to tell us about? _____

Do you participate in sports or exercise? YES NO If yes, what types and how often?_____

Have you lived independently in the past? YES NO

What does living independently mean to you? _____

_____

_____

_____

In what ways do you think Walden Living could support your recovery? _____

_____

_____

_____

Please circle any areas of concern regarding independent living:	Maintaining ADL's Maintaining Healthy Living Environment Menu Planning Meal Preparation/Cooking Creating Balance Interpersonal skills Implementing Coping skills into daily living Other:	Grocery Shopping Budgeting Scheduling and/or Time management Development of hobbies/interests Community Involvement Structure and/or Flexibility Body Image

How do you think living without symptoms will impact your life?_____

_____

_____

_____

Any additional information you would like the staff at Walden Living to know about you?_____

_____

_____

_____

If you have any questions about Walden Living, or would like to further discuss our program services, please contact our Manager of Program Services, Genna McCormick at 262-443-7192 or via email at genna@waldenliving.com. Please fax completed forms to 262-244-1434.

Prospective Client Signature: _____ Date: _____

Walden Living Staff: _____ Date: _____