New/Referred Eating Disorder Intake Form

TRIBECA PEDIATRICS
We care for your kids

Thank you for sharing the following information in advance of your visit.
Answer the best you can; we will go over everything together.

Patient's name (First/Last) ________________________ Date of Birth ________________

Who referred you to Dr. Dodson for this consultation? ________________________

Does your child have any history of medical issues or surgeries? ☐ No ☐ Yes *(Please list below)*

____

Does your child take any medications? ☐ No ☐ Yes *(Please list)* ________________________

Any allergies to medications? ☐ No ☐ Yes *(Please list)* ________________________

When did your child's eating habits change?

____

What behaviors has your child engaged in? *(Examples: Cutting out food groups, counting calories, restricting portions)*

____

Has your child purged (vomited) as a means of losing weight? ☐ No ☐ Yes

(IF APPLICABLE) When was your child's first period? ________________________

(IF APPLICABLE) Have periods become irregular, or disappeared altogether?

____

What is the highest weight your child had, before their eating started to change? ________________

What is the lowest weight your child reached, as a result of these eating changes? ________________

Has your child been in any hospital or treatment program for eating disorders? ☐ No ☐ Yes *(Please list below)*

____

If your child has a current therapist and/or psychiatrist, please list their name(s) and contact info:

____

(IF APPLICABLE) Would you like Dr. Dodson to reach out to your child's therapist/psyschiatrist in advance of your visit? ☐ No ☐ Yes *(This will serve as written permission)*

____

Parent/Guardian Name *(Print)* Parent/Guardian Signature

Please share childhood GROWTH CHARTS (Height, Weight, and BMI)
and any RECENT LABWORK before the visit if you can.
Email form to: **adolescents@tribecapediatrics.com**