Homewood Health Centre

Eating Disorders Program

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Homewood Health Centre offers the largest inpatient eating disorders program in Canada.
Our programs helps persons aged 16 and older regain control over their lives.

Program Philosophy

Homewood's Eating Disorders Program provides a group-based, recovery-oriented treatment approach which encourages responsibility and healthy coping from the start of treatment.

Patients receive care in a supportive community of peers and work with inter-professional staff who fully understand the complexities of the illness and the healing process.

Opportunities are provided to practice newly acquired coping skills throughout treatment in order to facilitate learning and improve the transition home. Such opportunities include cooking in the program's kitchen, community outings and planned passes home (where practical). Our program provides a strong foundation to build upon when patients return to their communities.

Our program helps patients:

- Learn about proper nutrition, exercise, and other aspects of eating disorders
- Cope with emotional difficulties without self-defeating food and weight manipulation
- Develop and restore healthy attitudes and eating habits
- Develop and practice a range of healthy coping techniques
- Increase self-awareness
- Improve family, marital and personal relationships
- Take responsibility for their progress in the recovery process

For More Information

Please contact the Program Director at 519-824-1010 ext. 2292 or eatingdisorders@homewoodhealth.com

homewoodhealth.com

Homewood Health | Santé

Eating Disorders Program

Program Description

During the first week of the program, a comprehensive assessment of eating disorder symptoms and ability to engage in the program will be completed.

Following assessment, a period of symptom interruption may be necessary to improve symptom management and ensure medical stability. Programming is modified at this time to allow for rest and adjustment.

Full programming is initiated once symptoms are adequately stabilized. Treatment includes support for the maintenance of healthy eating, weight, and physical activity.

Evidence based group therapy approaches include:

- Motivation Enhancement
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy

Individual and family therapy are offered, allowing for personalized treatment. In these sessions, patients often focus on the areas of anxiety, perfectionism, mood, addictions, and trauma.

The final four weeks of the program are used to help integrate the patient back into community, family and possibly employment. With staff support, patients are offered an opportunity to practice the skills they have learned during outings within the community.

The program operates on a treatment-to-outcome model, with patients returning home when they are capable. The average length of stay is approximately 16 weeks.

Admission Criteria

Admission to the Eating Disorders Program is for individuals who:

- Are 16 years of age or older
- Have a diagnosis of Anorexia Nervosa or Bulimia Nervosa
- Are ready and willing to work in a group format
- Are motivated to come into the program
- Are willing to gain weight if recommended by the treatment team
- Are willing and able to eat solid foods
- Have normal lab results (Na, K, and EKG) that are current (within four weeks)
  (abnormal findings must be reviewed by a Homewood physician for approval and acceptance into the Eating Disorders Program)

Aftercare Planning

Prior to discharge we will assist patients in developing outpatient contacts in their respective home communities.

3% of females suffer from an eating disorder in their lifetime

"I'm returning home a completely different person. I've learned skills to cope with my feelings in a more normal way and, for the first time in a long time, I finally feel alive!"

1 in 10 people suffering from an eating disorder is male

"A perfect balance of compassion and support, and action-focused recovery expectations. The first time I ever received help that provided me with any measure of success."

"I found all staff to be very approachable, understanding and supportive. Great teamwork! I feel privileged to have had this life-changing opportunity."

For More Information

Please contact the Program Director at 519-824-1010 ext. 2292 or eatingdisorders@homewoodhealth.com.

Homewood Health Centre
150 Delhi St., Guelph ON N1E 6K9
Telephone: 519-824-1010 ext. 2292 | Fax: 519-824-8751

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Date of Referral: _____

Referral Form for Admission to Homewood Health Centre

Patient Information

Patient Name:		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	Email Address:	
Telephone:	Business/Mobile Phone:	
Date of Birth (YYYY-MM-DD):		Gender:
Health Card Number:		
Version Code:	Expiry Date:	
Department of National Defense Blue Cross Service # (if applicable):		
Veterans Affairs Canada K # (if applicable):		

Referring Clinician Information

Your Name:		
Your Health Care Discipline e.g. Family Medicine, Social Worker: _____		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	Email Address:	
Telephone:	Fax:	
OHIP Billing # (if referred by an Ontario Physician or Nurse Practitioner):		
Are you referring as part of:	☐ WSIB ☐ DND ☐ VA ☐ Other Agency:	
☐ No ☐ Yes Will you provide this patient care after discharge? If not, who will: _____		

In order to arrange a timely admission to the most appropriate program, please provide us with clinical information, dating back at least 2 years. Copies of past consults, test results and discharge summaries are very helpful.

Primary Reason for Referral:

Please indicate if referring to Whole Recovery Assistance Program (WRAP) AMS ☐ AMS-PTSR☐

Please check all the problems your patient has and star your primary concern:

In the last 6 months	Prior to 6 months ago		In the last 6 months	Prior to 6 months ago	
☐	☐	Eating Disorder	☐	☐	Suicide Attempts
☐	☐	Substance Abuse (drug and/or alcohol)	☐	☐	Schizophrenia
☐	☐	Addiction (drug and/or alcohol)	☐	☐	Bipolar Disorder
☐	☐	Chronic Pain	☐	☐	Major Depression
☐	☐	History of Abuse or Trauma	☐	☐	Hypomania
☐	☐	PTSD (post-traumatic stress disorder)	☐	☐	Mania
☐	☐	Self-Harm (e.g. cutting, burning self)	☐	☐	Violence
☐	☐	Personality Disorder	☐	☐	Aggression
☐	☐	Dementia	☐	☐	ADHD
☐	☐	Social Phobia	☐	☐	Flashbacks
☐	☐	Panic Disorder	☐	☐	Nightmares
☐	☐	OCD (Obsessive Compulsive Disorder)	☐	☐	Dissociation
☐	☐	Multiple Personality (D.I.D)	☐	☐	Acute Psychosis (thought disorder/hallucination/delusion)
☐	☐	Cognitive Disorder (head injury, memory problems)	☐	☐	Chronic Psychosis (thought disorder/hallucination/delusion)

Section 1: Current Safety Risks (Check all that Apply)

☐ Wandering / AWOL Risk
☐ History of Violence Towards Self (self-harm)
☐ Current Passive Suicidal Thoughts
☐ Current Active Suicidal Thoughts
☐ History of Suicide Attempts, Date of Last Suicide Attempt: _____
☐ Risk of Falling, History of Recent Falls
☐ Current Thoughts of Harm to Others
☐ History of Violence Toward Others or Property
☐ History of Fire Setting

Please provide additional details regarding risks identified above:

Section 2: Recent Admissions

Has the patient had any psychiatric and/or medical hospitalizations within the last 5 years?
☐ Yes ☐ No If yes, where, when and why?

Please forward discharge notes or consults from hospital stays

☐ Yes ☐ No Is the patient currently in a hospital? If Yes, Where:_____

Admission date there:

☐ Yes ☐ No Is their current status involuntary? (certified inpatient)

Group Ready

☐ No ☐ Yes Is the patient able to participate in a group based program?

☐ No ☐ Yes Is the patient able to reside on an unlocked unit?

☐ Yes ☐ No Does the patient have a substitute decision maker?

☐ Yes ☐ No Is the patient subject to a Community Treatment Order (CTO)?

Section 3: Current Medications (psychiatric and other, e.g. insulin. Please list here or attach a list)

Name	Dosage	Frequency	Reason for Use

☐ Yes ☐ No Do they take prescribed opiates? (E.g. codeine, Methadone etc.) If yes, ☐ for pain, ☐ for addiction.

Current Height:	Current Weight:

Please indicate if the patient has tested positive for: ☐ C-Difficile ☐ MRSA ☐ VRE

Section 4: Addiction

☐ Yes ☐ No Does the patient currently have any drug or alcohol (substance) problems? If no, go to Section 5
If yes, their #1 substance of choice is:
Years of use: / Amount used per day:
If yes, their #2 substance of choice is:
Years of use: / Amount used per day:
☐ Yes ☐ No Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs (e.g., DTs, psychosis, seizures or hallucinations)? If yes, describe:
☐ No ☐ Yes Does the patient admit to having a drug or alcohol problem?
Methadone or Suboxone Use **(note: some programs have specific admissions requirements concerning Methadone treatment.)**
Is the patient currently prescribed Methadone? ☐ Yes, Dosage_____ mg/day ☐ No. Suboxone? ☐ Yes ☐ No
This is for ☐ addiction treatment ☐ chronic pain management
☐ No ☐ Yes Is the patient willing to taper off Methadone or Suboxone, if necessary?
☐ Yes ☐ No Is the patient using medical marijuana?

Section 5

If you are referring to the **Eating Disorders Program** additional information will be needed. Forms will be forwarded to the patient.
If you are referring to the **Program for Traumatic Stress Recovery**, please indicate all the types of trauma the patient has experienced: ☐ Violence ☐ Accident ☐ Occupational ☐ Military ☐ Childhood ☐Other:_____

Who will provide care post-discharge from Homewood?

Name:		
Health Care Discipline: _____		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	Email Address:	
Telephone:	Fax:	

Thank you for your referral to Homewood Health Centre. Please advise your patient to complete and submit the Patient Information Form (available online at www.homewoodhealth.com).

All forms and copies of past records and reports should be sent as soon as possible to:
Admission Department, Homewood Health Centre
150 Delhi Street, Guelph ON N1E 6K9
PH: 519.767-3350 ● T/F: 866.839.2594 ● FX: 519.767.3533 ● EM: admit@homewoodhealth.com

We will contact you once a decision has been made regarding your patient's admission. If you have any questions, please contact our Admitting Office at 519.767.3550. We are available Monday through Friday (excluding holidays) from 8:30 AM to 9:00 PM EST.

Homewood Health Centre

PATIENT INFORMATION FORM

Proud to be smoke-free tobacco-free

You have been referred for admission to Homewood Health Centre. To prepare for your arrival, we need some information from you. If you are unable to complete this form by yourself, you can ask a friend or relative to help you complete it, or you may phone Homewood's Admitting Department for assistance.

Please complete this form in black ink and return it to: **Admitting Department**
150 Delhi Street, Guelph ON N1E 6K9
Fax: 519.767.3533 **Email:** admit@homewoodhealth.com
Phone: 519.767.3550

PATIENT CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Title: _____ Last Name: _____ Given Name: _____

Preferred Name: _____ Middle Name: _____ Alias: _____

Maiden Name: _____ Mother's Maiden Name: _____ Gender: _____

Address: _____ ❑ Transient

City: _____ Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business Phone: _____ Ext: _____ Mobile phone: _____

Email: _____ Date of Birth: _____

Preferred method of contact: ❑ Phone ❑ Email

Health card number: _____ Version code: _____ Issuing Province: _____

Health card name (if different from above): _____ OR reason for no HC#: _____

EMERGENCY CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Name: _____ Relationship to Patient: _____

Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business/Alternate Phone: _____ Email: _____

SECOND EMERGENCY CONTACT INFORMATION (please provide telephone number(s) where messages can be left)

Name: _____ Relationship to Patient: _____

Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Phone: _____ Business/Alternate Phone: _____ Email: _____

REFERRAL SOURCE CONTACT INFORMATON

Name of Referring Physician or Clinician: _____

Name of Disability Case Worker: _____

Family Physician: _____ Address: _____

Phone: _____

What type of accommodation are you requesting? ❑ Ward ❑ Semi-Private ❑ Private

Reason for admission: _____

PATIENT INFORMATION

Do you have a history of setting fires? ❑ Yes ❑ No

Are you currently involved in a clinical drug study/trial? ❑ Yes ❑ No If Yes, explain: _____

Are you aware that some programs require supervised urine testing (as per program policies)? ❑ Yes ❑ No

Are you coming for treatment because of a court order? ❑ Yes ❑ No

Will you be bringing your vehicle for paid parking? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Please list any allergies (e.g., medication, foods, insects): _____

_____

Marital Status: ❑ Single (never married) ❑ Married ❑ Common Law ❑ Divorced ❑ Separated ❑ Widowed

With whom are you currently living? _____

Do you have children? ❑ Yes ❑ No If Yes, please complete the following:

Name	Age	Quality of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education:
❑ College (completed) ❑ University (BA Level) ❑ University (MA, PhD)
❑ University/College (partial) ❑ Secondary (completed) ❑ Secondary (partial)
❑ Technical/Trade school ❑ Elementary (grade 8 or less) ❑ Unknown

Employment status:
❑ Full-time employment ❑ Part-time employment ❑ Employment Insurance
❑ Retired ❑ Disability assistance (private) ❑ Homemaker
❑ Student/Retraining ❑ Unemployed seeking work ❑ Unemployed not seeking work
❑ Ont. Disability Support Prgm (ODSP) ❑ Guaranteed Income (pensions) ❑ Unknown Financial Status
❑ Family support/inheritance ❑ Social Assistance ❑ Other (investment/student loan)
❑ Disabled ❑ No income ❑ Other

If you are not working, when were you last employed? _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Source of income: ❑ Employed ❑ Social assistance ❑ Other income ❑ No income ❑ Employment Insurance ❑ Pension ❑ Disability Insurance

Height: _____ Weight: _____ Are you of Aboriginal Origin? ❑ First Nation ❑ Inuit ❑ Métis ❑ Not Aboriginal ❑ Unknown ❑ Not Applicable

Are you fluent in English ❑ Yes ❑ No ❑ Other preferred language: _____

Do you have difficulty reading? ❑ Yes ❑ No Do you have difficulty writing? ❑ Yes ❑ No

Please indicate any religious beliefs or practices that may affect your treatment: _____

Do you smoke? ❑ Yes ❑ No

Have you ever received a pneumonia vaccination? ❑ Yes ❑ No If Yes, please provide date (YYYY-MM-DD): _____

Date of last flu shot (YYYY-MM-DD): _____

Do you have any history of self-harm (cutting, burning, etc.)? ❑ Yes ❑ No Past suicide attempts? ❑ Yes ❑ No

Additional comments: _____

_____

_____

PROSTHETICS/MOBILITY

❑ Prosthetic leg
❑ Prosthetic arm
❑ Lower Denture
❑ Upper Denture
❑ Partial Bridge
❑ Other needs _____

❑ Glasses
❑ Contacts
❑ Hearing problems
❑ Hearing aids
❑ CPAP machine

❑ No problem walking
❑ Mobility aids (wheelchair, cane, walker, scooter, crutches)
❑ Transfer assistance needed
❑ Vision problems

Do you require a service animal? ❑ Yes ❑ No

DISCHARGE PLANNING

After discharge, would you have concerns about any of the following? (Check all that apply.)

❑ Child care issues ❑ Personal safety ❑ Crisis support ❑ Support for activities of daily living

PRIOR ADMISSIONS, CURRENT OUT-PATIENT SERVICES, ACTIVE SELF-HELP GROUPS

Please list any admissions to Homewood and/or other psychiatric or addiction facilities:

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Year admitted: _____ Facility: _____ Length of Stay: _____

Number of admissions to Homewood: _____ Number of admissions to other facilities: _____

Are you currently using any out-patient services? ❑ Yes ❑ No If Yes, please provide details:

Name of Service: _____

Contact: _____ Telephone: _____

Name of Service: _____

Contact: _____ Telephone: _____

Name of Service: _____

Contact: _____ Telephone: _____

Are you currently participating in any self-help groups? ❑ Yes ❑ No If Yes, please list: _____

_____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Country: _____ Phone: _____

Have you used another pharmacy in the last year? ❑ Yes ❑ No ❑ Unknown

DRUG PLAN INFORMATION

Do you have a drug plan? ❑ Yes ❑ No If No, how do you currently pay for drugs? _____

Please note: for ODSP, Trillium and other Ontario Government social service programs, there is an online list that your Homewood doctor can consult to ensure the prescribed medications are covered.

BILLING

If you are requesting semi-private or private accommodation, please complete this section:

Are you self-paying for your accommodation? ❑ Yes ❑ No

If you are self-paying (in part or in whole), please indicate the method of payment:

❑ Cash ❑ Major Credit Card ❑ Cheque

If you are not self-paying, please provide the following information:

Name of Payer: _____ Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Country: _____ Phone: _____

Please note: *30 days' payment is due on the date of admission. Please refer to financial information provided by the Admitting Department.*

INSURANCE INFORMATION ***(Note: an employee number is mandatory for all Chrysler Corporation patients requesting payment through insurance)***

Primary Insurer:

Name of Insurance Company: _____ Employee Number: _____

Group Policy Number: _____ I.D. or Certificate Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth (YYYY-MM-DD): _____

Subscriber's Employer: _____ Employer's Phone Number: _____

Employer's Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Patient's Relationship to Policy Holder: ❑ Holder ❑ Spouse ❑ Dependant ❑ Student (full-time) ❑ Student (part-time)

Secondary Insurer:

Name of Insurance Company: _____ Employee Number: _____

Group Policy Number: _____ I.D. or Certificate Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth (YYYY-MM-DD): _____

Subscriber's Employer: _____ Employer's Phone Number: _____

Employer's Address (if different from above): _____ City: _____

Province/State: _____ Postal/Zip Code: _____ Country: _____

Patient's Relationship to Policy Holder: ❑ Holder ❑ Spouse ❑ Dependant ❑ Student (full-time) ❑ Student (part-time)

Although you may have semi-private or private coverage, you should be aware that some insurance companies do not cover accommodation at Homewood Health Centre Inc. To avoid unexpected charges, we strongly suggest that you obtain written verification that your insurance company will cover the cost of your stay at Homewood prior to admission. Please note: you are responsible for payment of your semi-private or private accommodation if your insurance company does not cover the cost.

Please ask your insurance company the following questions:

1. *Does my insurance cover the cost of semi-private or private accommodation for mental illness/addiction treatment at Homewood Health Centre Inc.?*
2. *What is the maximum amount of money or maximum length of stay covered by my insurance?*

Our practice with some insurance companies is to email information for verification. Please contact us if you are not in agreement with this process. Please sign below authorizing Homewood to verify the accuracy of the above insurance information with your insurance company and/or employer (Note: when verifying this information with the insurance company, it may be necessary to share the reason for admission.)

Name of Employer: _____ Name of Insurance Company: _____

Signature: _____ Date: _____

Homewood is compliant with current privacy legislation. Homewood collects personal information for assessment and treatment, as well as for operational and organizational, research and teaching, and legal and regulatory purposes. For questions or concerns contact the Privacy Office at privacy@homewoodhealth.com or 519.824.1010, extension 2443.

Homewood
Health Centre

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Re: Admission to Homewood Eating Disorders Program

Dear Healthcare Professional:

We have received a referral to the Eating Disorders Program on behalf of your patient.

To complete this process, the following information is required:

1. The **Eating Disorders Program Assessment Form**, completed by a Physician.
2. Your patient's **sTSH, GGT, CBC, Calcium, Magnesium, Creatinine, Phosphorus, Fasting Blood Sugar and Electrolyte Panel-Sodium/Potassium/Chloride/Bicarbonate/** values. (within the previous month).
3. Your patient's **results of a recent ECG** (within the previous month).
4. The **Eating Disorders Program Questionnaire**, completed by your patient.
5. The **Patient Information Form**, completed by your patient.

In order to confirm your patients continued medical stability while on the waitlist, you may be contacted to provide updated lab work and ECG.

Please return the above information to our office as soon as possible. If you wish to fax this information, please use our confidential fax number, which is 1-855-704-0501.

If you have any questions, please contact the Admitting Department at 1-519-824-1010 x2300.

Thank you,

Admitting Department
Homewood Health Centre

Homewood
Health Centre

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Psychiatry Services

TO BE COMPLETED BY FAMILY PHYSICIAN AND FAXED TO:
ADMITTING DEPARTMENT **519-767-3533** (Please use black ink.)

EATING DISORDERS PROGRAM ASSESSMENT FORM

1. PATIENT'S NAME _____ Height ft/in:_____ Weight: lbs_____

Name of Patient's Physician: _____

2. CHIEF COMPLAINT AND HISTORY OF PRESENTING ILLNESS:

_____

_____

_____

3. CURRENT MEDICATIONS:

NAME	DOSE	NAME	DOSE	NAME	DOSE

b) Any concerns re: abuse of prescription drugs or over-the-counter medications? _____

_____

4. PSYCHIATRIC HISTORY:		**PAST**	**PRESENT**	**NOT APPLICABLE**	
4.1	Hospital Admission	☐	☐	☐	Where/When/Reason
4.2	Out-patient Program	☐	☐	☐	Where/When/Reason
4.3	Suicidal Behaviour	☐	☐	☐	
4.4	Aggressive Behaviour	☐	☐	☐	
4.5	Substance Abuse	☐	☐	☐	
4.6	Legal Involvement	☐	☐	☐	
4.7	Abuse:				
	I) Physical	☐	☐	☐	
	II) Emotional	☐	☐	☐	
	III) Sexual	☐	☐	☐	

Name of Patient: _____

5. LABORATORY INVESTIGATIONS:

The following are mandatory tests required - please provide results.

sTSH _____ CBC _____ Electrolytes _____

Blood Glucose _____ BUN _____ Creatinine _____

Urinalysis _____ ECG (please provide interpretation)

(Please provide any other tests results you have available on this patient.)

6. PHYSICAL ASSESSMENT:

a) Past Medical History

Major Illness: _____

Major Surgery: _____

Head Injury: _____

Seizures: _____

Hepatitis: _____

HIV: _____

Cardiac Arrhythmia: _____

Hypokalemia: _____

GI Complications: _____

Other: _____

b) Present Physical Condition	**Normal**	**Abnormal**
Blood Pressure	☐	☐
Heart Rate	☐	☐
Respiratory	☐	☐
Neurological	☐	☐
Cardiovascular	☐	☐
Gastrointestinal	☐	☐
Genitourinary	☐	☐
Hearing/Sight	☐	☐
Musculoskeletal (i.e., osteoporosis)	☐	☐
Endocrine (i.e., diabetes, thyroid)	☐	☐
Dermatology	☐	☐
L.M.P.	☐	☐
Menopause	☐	☐
Ob/Gyn (i.e., pregnancy, STDs)	☐	☐

Name of Patient: _____

7. PHYSICAL HEALTH

Has your patient ever had any of the following symptoms **related to his/her eating disorder**?

	Yes	Duration
Fainting	☐	_____
Seizures	☐	_____
Blood in vomitus	☐	_____
Edema (swelling)	☐	_____
Missed menstrual periods	☐	_____

8. *__ADDITIONAL COMMENTS__: (Please explain any abnormal findings.)

_____
_____
_____
_____
_____

Date: _____ Signature: _____

Homewood
Health Centre

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Psychiatry Services
Eating Disorders Program Questionnaire **Name:** _____

TO BE COMPLETED BY THE PATIENT (Please use black ink.)

EATING DISORDERS PROGRAM QUESTIONNAIRE

Please note: This questionnaire must be completely filled out and returned to **the Admitting Department – Psychiatry Services**, Homewood Health Centre, before we can confirm your suitability for the program. All information will be kept strictly confidential**.**

IDENTIFYING INFORMATION

Date: _____ Name: _____
First Middle Last

EATING DISORDER HISTORY

1. Current Weight: _____ lbs. 2. Current Height: _____ ft./in.

3. Desired Weight: _____ lbs. 4. Highest Past Weight: _____ lbs. Age at time: _____

5. Lowest Past Weight (since age 16): _____ lbs. Age at time: _____

6. At your current weight, do you feel that you are:

extremely thin	somewhat thin	normal weight	moderately overweight	extremely overweight
_____↑	_____↑	_____↑	_____↑	_____↑_____

7. During the past three months, which of the following behaviour have you engaged in?

		YES	NO
a.	Restricting calorie intake	☐	☐
b.	Avoiding carbohydrates	☐	☐
c.	Avoiding fat in food	☐	☐
d.	Fasting	☐	☐
e.	Chewing and spitting out food	☐	☐
f.	Binge eating (feeling out of control while eating)	☐	☐
g.	Vomiting (after eating)	☐	☐
h.	Exercise to control weight - describe type and time spent _____	☐	☐
i.	Exercise to cope with emotions - describe type & time spent _____	☐	☐
j.	Exercise that is difficult to stop - describe type & time spent _____	☐	☐
k.	Use of diet pills (name of pill/amount per day_____)	☐	☐
l.	Laxative use (for weight control), including laxative/cleansing teas (name of pill, amount per day_____)	☐	☐
m.	Use of diuretics	☐	☐
n.	Use of enemas	☐	☐
o.	Use of Ipecac	☐	☐
p.	Fluid loading to numb hunger (i.e. water, diet drinks, coffee, tea)	☐	☐
q.	Thinking a lot about food, weight, or exercise (please underline all that apply)	☐	☐
r.	Being fearful about gaining weight	☐	☐

8. Do you have problems with anxiety or depression? Please describe. _____

_____

9. At the present time, are there any factors that could interfere with you fully participating in this group-based program?

_____

ALCOHOL AND DRUG USE

1. Please specify the amount of alcohol consumed in an average week, including a weekend. What do you drink? Do you drink alone, or socially?

_____

2. If you are presently using street drugs, please specify type, amount, and current usage pattern.

_____

3. If you are presently abusing prescription drugs, please specify type, amount, and current usage pattern.

_____

4. Do you or anyone who knows you think you might have an alcohol or drug problem?

_____

5. The Eating Disorders Program has a zero tolerance policy for drug and alcohol use while in the program. Do you anticipate any problems being abstinent?

_____

RELATIONSHIP HISTORY

1. Current Living Arrangement:

□ alone □ with parents □ dorm or shared accommodation
□ married or cohabitating □ single with children (please list their ages) _____

2. What do you consider to be possible factors contributing to your eating disorder (e.g., family or relationship difficulties, environmental stresses, life changes, media influences, psychological issues, etc.)?

_____

_____

_____

3. Please list any relatives who have suffered from an eating disorder, depression, alcohol abuse, or other emotional problems.

_____

_____

If an eating disorder, please specify, including present condition and treatment:

_____

_____

TREATMENT HISTORY

1. Please describe any treatments attempted for your eating disorder, including the names of hospitals, professionals seen, and dates of contacts. Which treatments have been the most effective? Least effective?

_____

_____

_____

_____

2. Please describe any treatment for any other psychological issues, including previous medications.

_____

_____

_____

TREATMENT GOALS

1. Please specify what goals you would like to work towards in an in-patient treatment setting.

_____

_____

_____

_____

Date: _____ Patient Signature: _____

If you have any questions regarding this form, please contact the Program Director at 519-824-1010, extension 2292.

Please return the completed questionnaire to:

Admitting Department – Psychiatry Services
Homewood Health Centre
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