KLEDC
KARIN LEWIS EATING DISORDER CENTER, LLC

CLIENT INTAKE FORM

(please print)

CLIENT INFORMATION			
CLIENT NAME:			
	LAST	FIRST	M.I.
DATE OF BIRTH:	________/______/_________		
STREET ADDRESS:			
CITY/STATE:		ZIP CODE:	
HOME PHONE: ( ) -		WORK PHONE: ( ) -	
CELL PHONE: ( ) -		CONTACT PREFERENCE:	
EMAIL:			
EMPLOYER:			
PRIMARY CARE PHYSICIAN NAME & PHONE:			
REFERRAL SOURCE:			
EMERGENCY CONTACT NAME & RELATIONSHIP:			
EMERGENCY CONTACT PHONE:			

Why are you inquiring about therapy today? ___________________________

____

____

____

Please respond to the following for current symptoms:

Do you, or have you ever had an eating disorder? Please explain: _______

____

Do you exercise? Please explain: _____________________________________

____

Do you drink caffeine? Please explain: ________________________________

____

Do you smoke? Please explain: _______________________________________

____

Do you drink alcohol? Please explain: ______________________________

____

Do you use elicit and/or recreational drugs? Please explain: ___________

____

Do you, or has anyone in your family ever been diagnosed with a substance abuse disorder? Please explain: __________________________________

____

Do you have any sleep issues? Please explain: ______________________

____

On average, how many hours do you sleep per night? ________________

Medical History:

Do you have any previous/present medical conditions? Please explain:

____

____

____

When was your last physical examination? __________________________

Do you, or have you ever been diagnosed with a heart condition? Please explain: ____

____

Do you, or have you ever been diagnosed with a thyroid condition? Please explain: ____

____

Do you have high blood pressure? Please explain: ___________________

____

Are you, or have you ever been in an abusive relationship? Please explain:

____

Do you, or have you ever been suffered from suicidal thoughts? Please explain: ____

Have you ever been hospitalized? Please explain: ___________________

____

____

Do you take medication? ____

If yes, please list all current medications including over-the-counter medications:

Medication	Dose	Frequency

Prescriber Name: ____

Type of prescriber (PCP/Psychiatrist/RN): ______________________________

Address: ____

Phone number: ____

Do you have any co-occuring conditions and/or medical concerns not mentioned above? Please explain: ___________________________________

____

____

____

____

KARIN LEWIS EATING DISORDER CENTER, LLC

399 Boylston Street, 9th Floor
Boston, MA 02116
857-243-0056

- All appointment cancellations must be completed at least 48 hours in advance. Failure to cancel an appointment with at least 48-hours notice or not showing up to an appointment without any notice will result in a FULL SESSION fee that must be paid by the patient.
- After 2 cancellations patient may be charged for the next cancellation, even if it is made more than 48 hours in advance.
- Appointments start and end on time. If a patient is 20 or more minutes late to an appointment, the appointment will be considered canceled and the patient will be required to pay the full fee as explained above.
- There will be a service for all returned checks.

By signing below, I acknowledge that I have read, understand, and agree to the above policy.

Printed Name: ____

Signature: ____

Date: ___/____/_____

Parent/legal guardian signature is required for any patient under 18 years of age.

Printed Name: ____

Signature:____

Date: ___/____/_____

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

Virtual Eating Disorder Therapy and Recovery Coaching

Video conferencing may not be a confidential method of communication unless done through a HIPAA compliant tele-health platform. Please be advised that Skype, Google Hangouts and FaceTime are not HIPAA compliant.

Response Time

While we try to respond to messages in a timely manner, we cannot assure an immediate response. For voicemails and other messages, you can expect a response within *24 hours* (weekends ad holidays are an exception to this timeframe). We cannot always guarantee a response to messages and emails within 24 hours, however. If you do not receive an answer to a routine e-mail or text message within two working days, please call us directly.

Emergency Contact

I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. **If you are ever experiencing an emergency, including a mental health crisis, please call *911 or go to your closest emergency room*.**

I ____________________________ (print name) acknowledge that I have been provided a copy of Karin Lewis Eating Disorder Center's ***CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS***.

Printed Name of Client: ____

Signature of Client: ____________________________________ Date: ________________________

Signature of Parent: ____________________________________ Date: ________________________

(or Guardian if < 18 yrs. old)

Authorization for Release of Confidential Information/Records

____ ________________

CLIENT NAME (please print) DOB

I hereby authorize the Karin Lewis Eating Disorder Center, LLC:

- ☐ to **OBTAIN** information regarding my care from the below named individual/agency
- ☐ to **RELEASE** information regarding my care from the below named individual/agency

This information may include:

- ☐ Telephone conversations regarding diagnosis and treatment
- ☐ Psychiatric evaluations and discharge summaries
- ☐ Medical Records
- ☐ Other ____

To individual/agency requesting/releasing information:

____ ____________________

NAME PHONE/FAX

____

ADDRESS

I have carefully read and understand the above statements and do hereby expressly and voluntarily consent to disclosure of the above information and/or medical records to those persons/agencies named above. This authorization may pertain to information related to alcohol and drug use/addiction.

I further release Karin Lewis Eating Disorder Center, LLC and any other individuals/agencies named from any liability arising from the release of information, provided the information is released in accordance with applicable law.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire one year from the date signed.

____ __________________

CLIENT/GUARDIAN SIGNATURE DATE