

## Patient Form

Fax: 416-595-6399 – to Attention: **Eating Disorder and Addiction Clinic,**

**Today's Date (dd/mm/yyyy):** \_\_\_\_\_

First Name: \_\_\_\_\_ Date of birth (dd/mm/yyyy): \_\_\_\_\_

Last Name: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_ Okay to leave a confidential message? Y N

Health Card Number: \_\_\_\_\_

Gender Identity: female\_\_\_ male\_\_\_ transsexual\_\_\_ transgendered\_\_\_ genderqueer\_\_\_  
two-spirit\_\_\_ FTM (female-to-male)\_\_\_ MTF (male-to-female)\_\_\_ intersex\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Type of Eating Disorder (if known):

### CURRENT EATING DISORDER BEHAVIOUR

Behaviour	Yes	No	# Per Day	# Per Week	Approximate Date of Onset/ Duration
Food Restriction					
Binge					
Vomiting					
Laxatives					
Diuretics					
Diet Pills					
Exercise					
Other: _____					

**WEIGHT AND HEIGHT**

<b>Weight</b>		<b>Height</b>	
Date taken (dd/mm/yyyy):		Date taken (dd/mm/yyyy):	
Kg:	Lbs:	Cm:	Ft/In:
Previous Weights Lowest:           kg/ lbs  Date (dd/mm/yyyy) of Lowest:  Highest:           kg/lbs  Date (dd/mm/yyyy) of Highest:			

Description of Eating Disorder:

Presence of current or past problematic substance:    Y   N  
(includes illegal substances, alcohol, cigarettes, prescription medications, and gambling)

**CURRENT AND PAST SUBSTANCE USE**

Substance	Please circle Y or N				Approximate Date of Onset/Duration	Amount Per Day	Amount Per Week
	<i>Current</i>		<i>Past</i>				
Alcohol	Y	N	Y	N			
Cocaine	Y	N	Y	N			
Cannabis	Y	N	Y	N			
Methadone	Y	N	Y	N			
Heroin	Y	N	Y	N			
Other Opiates/ Analgesics	Y	N	Y	N			
Barbiturates	Y	N	Y	N			
Other sedatives/ hypnotics	Y	N	Y	N			
Amphetamines	Y	N	Y	N			

Substance	Please circle Y or N	Approximate Date of Onset/Duration	Amount Per Day	Amount Per Week	Substance	Please circle Y or N	Approximate Date of Onset/Duration
Hallucinogens	Y	N	Y	N			
Tobacco	Y	N	Y	N			
Gambling	Y	N	Y	N			
Other: _____	Y	N	Y	N			

Description of substance use:

**MEDICATIONS:**

Prescribed: Name(s) & dose(s)
Non-Prescribed: Name(s) & dose(s)

**PRIOR MEDICAL DIAGNOSES AND/OR TREATMENT FOR THIS CONDITION AND/OR OTHER CONDITIONS**

Previous history of hospitalization for an Eating Disorder or Substance Use:    Yes _____    No _____  If Yes, when and where? :       Previous Outpatient Treatment for an Eating Disorder or Substance Use:    Yes _____    No _____ If Yes, when and where? :       Other medical diagnoses or concerns:    Yes _____    No _____ If Yes, please describe:       Prior psychiatric diagnoses and/or treatment:
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Centre for Addiction and Mental Health  
Centre de toxicomanie et de santé mentale

<input type="checkbox"/> Suicidal behaviour * (if yes, describe below)	<input type="checkbox"/> Suicidal Ideation or Intent
<input type="checkbox"/> Self Harm behaviour * (if yes, describe below)	<input type="checkbox"/> Borderline Personality Disorder
<input type="checkbox"/> OCD	<input type="checkbox"/> History of Abuse
<input type="checkbox"/> Depression	<input type="checkbox"/> History of Legal trouble (police involvement)
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Residential Treatment

\* If self-harm or suicidal behaviour: how many, when, what did you do, did you receive medical attention, and when was the most recent behaviour?:

**PHYSICIAN**

Do you have regular contact with a GP? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of GP: \_\_\_\_\_

Does your GP know about the eating disorder? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your GP know about the substance use? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your GP have any current concerns about your health? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, describe: \_\_\_\_\_

\_\_\_\_\_

Do you work or volunteer? Are there any days that you absolutely cannot come in for an appointment?:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

Thank you for completing this form.

Our treatment program is specialized for both substance use and mental health issues including eating disorders. The treatment program involves weekly group sessions and individual sessions depending on the treatment stream. The initial assessment process involves 2 to 3 appointments that will be booked as soon as possible. While you wait for the assessment, please maintain contact with your GP and explore other treatment options if on a wait list.

We require that you provide us with a referral from your GP or mental health professional. You will find the appropriate forms on our website (Letter for Physician, Referral Form 1, and Referral Form 2). Please fax this **Patient Form** to the **Eating Disorder and Addiction Clinic at 416-595-6399**. Please have your GP or health care practitioner complete and fax the **Referral Form 1** and **Referral Form 2** and the information requested on the **Letter for Physician**.