EATING DISORDERS CLINIC
INTAKE CHECKLIST

This form is to be taken to the GP for completion and brought to the first assessment at the Eating Disorders Clinic at The Resilience Centre.

Patient Name:_____ Date of Birth:_____

Medical Information	
General Practitioner details:	
Name	
Address	
Phone	
Email address	
Date of Mental Health Care Plan	
Other Referring Practitioners	
Name	
Address	
Phone	
Email address	
Provider number	
Date of Mental Health Care Plan	
Diagnosis (circle)	**EDNOS/Anorexia Nervosa/ Bulimia Nervosa/ Binge Eating Disorder/ PICA**
Date of Diagnosis	
Onset of events	
Current Medication	
Other conditions	

Family Information	
Family Structure	
Parents: (foster parents/guardians) Names Email addresses	
Siblings: Names / ages	
Grandparents: Names	
Other close family members: Names Email addresses	
Close supportive friends: Names Email addresses	

GENERAL PRACTITIONER TO COMPLETE

	Date	**Results (please circle) & attach**
Temperature		Normal range/ at risk/ at significant risk
Pulse		Normal range/ at risk/ at significant risk
BP		Normal range/ at risk/ at significant risk
Blood test		Normal range/ at risk/ at significant risk
ECG		Normal range/ at risk/ at significant risk
Height		Normal range/ at risk/ at significant risk
Weight		Normal range/ at risk/ at significant risk
BMI		Normal range/ at risk/ at significant risk
LMP		Normal range/ at risk/ at significant risk