The Charis Center for Eating Disorders
Indiana University Health

Adult Biopsychosocial Form

Please complete this form. It will provide us with important information about you and your treatment.

Patient's legal name_____ Nickname: _____Date of birth_____

Information given by: ___Self _____Other (name of person/relationship)

Gender _____ Pronouns_____ Primary spoken/written language_____

Race (American Indian, Alaskan Native, Asian, Black or African American, Hispanic, Native Hawaiian or Pacific Islander, White, other)
_____ Ethnicity (nationality) _____

Legal guardian name _____

Legal guardian relationship to patient ___mother ____father ___foster father ____foster mother ____sibling

___grandfather ___grandmother ____sibling ____spouse ____stepfather ____stepmother ____step sibling ____other

Military Service

___never in military ___Marines ___Air Force ___Army___ Coast Guard ___ National Guard ___Navy ___other

Current Military Status

___ active duty ___non-active duty ___discharge dishonorable ___reserves ___discharge general ___discharge honorable ___retired ___other

Rank _____ Time in service _____

Military occupation _____

Mental health treatment history

Description	Date	Hospital/Program	Therapist/Counselor	Comment

Medication

Medication Name/Dosage	Start/Stop Date	Effectiveness/Side Effects	Comments

Employment

Employment status ___employed full-time ___employed part-time ___unemployed ___retired ___full-time student ___part-time student ___self-employed ___seeking employment ___other _____

What is your current occupation? _____

Barriers to employment? (none, education, following instructions, housing, child-care, felony, getting along with others, health issues, housing, interview skills, other) _____

Sexuality

Sexual Orientation (heterosexual, homosexual, bisexual, other) _____

Sexually Active: ___Yes ___No Age of First Sexual Contact _____

Sexual Partners: ___Monogamous ___Multiple Sexual partner with sexually transmitted disease? ___Yes ___No

Type of contraception/protection_____

Any problematic sexual behaviors_____

Current Living Situation

Family Member/Significant Other/Other	Age	Relationship to Patient	Living with Patient	
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Please describe your type of living situation (single family home, apartment/condo, homeless, shelter, assisted living, extended care facility, foster home, group home, juvenile facility, multiple homes, other _____

Present personal relationship ___single ___cohabitation ___legally separated ___divorced ___estranged ___living together ___ married-civil ___ married-religious ___ separated ___widow(er)

Current dependents

Dependent	Age	Gender	Relationship

Significant family traumas ____N/A ____Yes. Please describe_____

_____

Important relationships Please note past marriages, divorces, and other important relationships.

_____

_____

_____

_____

Who were your primary caregivers as a child? _____

Are you adopted? ___Yes ___No

Degree of support received: Please describe support from family, friends, school, support groups and others

_____

_____

Family of origin: Please describe your relationships

Father	Supportive_____	Conflicted_____	Estranged_____
Mother	Supportive_____	Conflicted_____	Estranged_____
Step-Father	Supportive_____	Conflicted_____	Estranged_____
Step-Mother	Supportive_____	Conflicted_____	Estranged_____
Spouse	Supportive_____	Conflicted_____	Estranged_____
Children	Supportive_____	Conflicted_____	Estranged_____
Siblings	Supportive_____	Conflicted_____	Estranged_____
Step-Siblings	Supportive_____	Conflicted_____	Estranged_____
Significant Other	Supportive_____	Conflicted_____	Estranged_____
Other:	Supportive_____	Conflicted_____	Estranged_____

What are the areas of stress in your life? (finances, career, relationships, trauma, health, school, legal, other)

Alcohol abuse in household ___yes ___no **Substance abuse in household** ___yes ___no

Abuse or neglect in household ___no ___yes _____

Feel unsafe in home ___ yes ___ no **Safe place to go** ___yes ___no

Other risks in the home environment ___no ___yes _____

Agency(s)/Others notified ___ no ___yes Agencies: _____

What is your highest level of education? (some high school, high school diploma, some college, associate degree, bachelor's degree, graduate degree, other)

_____

Cultural & Spiritual

Please describe past and present religious affiliations, involvement in faith community and guiding spiritual practices

___None _____

Please describe any cultural issues/practices you would like us to be aware of that would affect your treatment

___None_____

Leisure activities: Please describe your hobbies, interests, stress management, social life and volunteer work, other

_____

Please indicate by a check if you or family members (including brothers, sisters, grandparents or your immediate family) have had any of the following conditions:

Condition	Patient	Family	Condition	Patient	Family
Diabetes			Musculoskeletal problems		
Skin Problems			Edema		
Allergies			Thyroid problems		
Eye trouble, poor vision			Obesity		
Ear, nose, throat problems			Hepatitis/liver disease		
Severe tooth/gum problems			Gallbladder disease		
Tuberculosis/+ skin test			Substance abuse (alcohol, drugs)		
Frequent colds			Frequent indigestion (heartburn)		
Shortness of breath			Frequent nausea/vomiting		
Asthma			Diarrhea/constipation		

Pneumonia			Rectal problems		
Cigarette smoking/marijuana			Recent gain/loss of weight		
High blood pressure			Kidney disease		
Rheumatic fever/arthritis			Urinary tract (bladder) infection		
Blood clots			Venereal disease (VD)		
Stroke/heart problems			Severe headaches		
Anemia			Convulsions		
Sickle cell			Dizzy spells/fainting		
High cholesterol			Severe depression/anxiety		
Mononucleosis			Birth defects		
Bleeding problems			Tumor/cancer		
Inherited diseases: Please list			Other mental health issues: List		

Eating and Sleeping Patterns

How would you describe your appetite? (good, fair, improving, poor, other) _____

Eating Behavior Concerns

Frequency and degree of restrictive eating (explain) _____

Age of first diet _____

Frequency and severity of binge eating (explain) _____

Frequency and severity of purging (explain) _____

Tool(s) used for purging? (exercise, laxatives, diuretics, diet pills, other) _____

_____

Additional Eating and Nutritional Concerns

nutrition concerns ___ constipation ___diarrhea ___mouth sores/unable to swallow ___ nausea/vomiting ___

constipation ___eating disorder ___enteral feedings ___fluid intake less than 50% of normal in last 3 days

impaired nutritional intake ___lactation ___skin breakdown or pressure ulcer___ TPN___

Additional Weight and Body Image Concerns

height _____ current weight _____ lowest weight/date _____ highest weight/date _____ goal weight _____

goal pant size _____ frequency of weighing _____ comments on weight/body: (body image, body checking, app usage, family/peers influence) _____

Do you have any disordered sleep? ___ No ___ Yes (explain)

_____

Does the patient have any disordered sleep? ___N/A ___Yes (explain)_____

_____

How many usual hours of sleep? _____Hrs.

Addictive behaviors ___none ___exercise ___internet/social media ___overeating ___sex ___shopping ___video/tv ___video games ___work ___school ___other _____

Current legal status ___none ___incarcerated ___parole ___probation ___pretrial release ___other: _____

number of previous incarcerations _____ supervising officer/case manager name and contact information _____

_____

Presenting problems

Reason for coming to treatment at this time _____

_____

Onset age of disordered eating behaviors _____ Triggering events influencing disordered eating? _____

_____

Any attempts to resolve disordered eating?

_____

What are your goals for coming to The Charis Center for Eating Disorders?

_____

What is your motivation to meet the goals? _____

Barriers to treatment? ___No ___Yes _____

Manager of financial affairs ___Self ___Other (describe) _____

Do you have an advanced directive? ___Yes ____No

Signature_____**Date**: _____**Time:** _____