Tanya Mickler, Ph.D., PA
Licensed Psychologist (PY 5842)

2653 SW 87th Dr., Suite A
Gainesville, FL. 32608
(352) 331-0020

INFORMED CONSENT FOR EVALUATION AND TREATMENT

PATIENT NAME:_____

I _____ hereby consent to evaluation and/or treatment of myself/my child rendered by Tanya Mickler, Ph.D. I agree, that should I present my child for evaluation and/or treatment, that I have legal authority to do so. I understand that it is my responsibility to maintain scheduled appointments, provide payment for services rendered, provide an accurate and complete account of current and past evaluations, treatment, symptoms, and complaints, follow through on agreed upon recommendations and provide any information necessary for insurance billing.

Confidentiality Disclosure:

Communication between client and therapist is considered confidential. However, I understand that the confidential nature of my records *may not be protected* under the following circumstances:
Suspicion or evidence of child abuse or neglect; Immediate danger to myself or others; Need for hospitalization; In the event that is becomes necessary to submit my charges to a collection agency for non-payment; Legal cases in which I am a plaintiff seeking medical or psychological damages; Legal cases in which I use my psychological status as a defense or mitigating circumstance; and cases involving health professionals who may be impaired or violating licensing statutes or rules.

Release of Information to Insurance:

I understand that Dr. Mickler may or may not be under contract with my insurance carrier and might or might not be able to file insurance claims for me. I understand that if Dr. Mickler is unable to file claims with my insurance carrier, it is my responsibility to provide payment for the services rendered and personally submit claims to my own insurance carrier for reimbursement. In the event that Dr. Mickler will be submitting claims to my insurance carrier, I hereby release any and all medical information to the insurance carrier necessary to process my claims. I reassign my benefits to Dr. Mickler, thus authorizing my insurance company to reimburse her directly for her services.

I understand that while mental health providers may substitute a summary of records, that insurance companies may still request the original record. In order to expedite claims, I authorize release of a copy of the original complete record to any requests for documentation by the insurance carrier or its representatives.

By signing below, I indicate my understanding of the above, agreement to the above terms and conditions, and that the above has been explained to me in terms that I understand. By signing below I also indicate that I have asked any questions I might have about the above terms and conditions and my questions have been answered. I agree to evaluation and treatment and agree to the above terms and conditions, and release of information.

Signature_____ Date_____

Signature of Witness_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- An employee of the provider's office obtains treatment information about you and records it in a health record
- During the course of your treatment, the provider determines that she will need to consult with another specialist in the area. She will share the information with such specialists and obtain input.

An example of use of your health information for payment purposes:

- We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding services rendered. We will provide that information to them about you and the care you receive.

An example of use of your health information for health care operations:

- The state licensing authority wants to review records to assure that we have acted consistent with state law regarding your care. In doing so, it wants to take a sampling which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact your healthcare practitioner (Tanya Mickler, Ph.D.) at Haile Market Therapy and Behavioral Medicine, (352) 331-0020, 2653 SW 87th Dr, Suite A, Gainesville, FL, 32608, in person, or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The provider is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information to you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our Notice or by visiting the office to obtain a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact your healthcare practitioner (Tanya Mickler, Ph.D.) at Haile Market Therapy and Behavioral Medicine, (352) 331-0020, 2653 SW 87th Dr, Suite A, Gainesville, FL, 32608.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to your healthcare practitioner (Tanya Mickler, Ph.D.) at Haile Market Therapy and Behavioral Medicine, (352) 331-0020, 2653 SW 87th Dr, Suite A, Gainesville, FL, 32608.

You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Uses and Disclosures

- We have Business Associates with whom we may share your protected health information.
  - For example, in preparing our annual financial statement, auditors may need to review samples of medical care given. We may disclose your health information to the accounting firm to prepare this material.
  - For example, during our routine health care operations, we may need to hire computer technicians and software vendors. We may disclose your health information to these vendors to maintain daily functioning in our health care operations.

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Marketing

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

To avert a serious threat or health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other uses
Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature:_____ Date:_____
Signature of Personal Representative of Patient:_____
Description of Representative's Authority to Act on behalf of Patient:_____

Tanya Mickler, Ph.D., P.A.
Licensed Psychologist (PY 5842)

2653 SW 87th Drive, Suite A
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PLEASE READ THIS CAREFULLY – PRACTICE POLICIES

Welcome to my practice. The following document was developed to explain my office practices and professional responsibilities. In lieu of spending time on administrative manners, please read this document carefully and sign. Any questions you have regarding this document will be answered during your first consultation appointment. When you sign this document, it will represent an agreement between us.

Psychological Services
Psychotherapy involves a commitment between client and psychologist to process the concerns presented for treatment. Our first few sessions will involve an evaluation of your needs, after which I will be able to provide an impression of what our work will include and a treatment plan to follow, if you should decide to continue with therapy. You should evaluate this information along with your own opinions as to whether you feel comfortable working with me. I will gladly discuss any concerns or questions you may have regarding my procedures and will provide you with the names of other professionals if you should desire a second opinion.

Clients generally receive the best benefit from psychotherapy when they take an active role in their own treatment. This involves working on the issues we discuss both during our sessions and at home, as well as doing your best to follow through with recommendations or discuss your limitations in doing so.

Individual and family therapy sessions will be 53 minutes (unless planned otherwise). Any necessary paperwork (session progress notes, insurance treatment authorization forms, letters), as well as coordination of care (i.e. phone calls to physicians, psychiatrists, etc.) need to occur as part of your 53-minute session time (either prior to the start, during or at the ending of the session). If these activities need to occur outside of, or in addition to, your session time, you will be billed at my standard hourly rate (see revised Financial Agreement form). Insurance does not cover these activities though they are expected as a part of necessary mental health care.

Office Hours
I am in the office on Mondays, Tuesdays and Wednesdays.

Phone Calls
If you wish to schedule or cancel an appointment, please call me at (352) 331-0020. If you are in crisis and need immediate assistance, you should go to the emergency room, call 911, or call the Alachua County Crisis Center at (352) 264-6789. You also may call my office and contact the answering service who will attempt to reach me.

Consent to Treatment/Confidentiality
Please read and sign the attached review of consent to treatment and confidentiality limitations.

By signing below, I indicate my understanding of, and agreement with, the above. By signing below I also indicate that I have asked any questions I might have about the above information and my questions have been answered. I have retained a copy for reference.

Signature_____ Date_____

Signature of Witness_____

FINANCIAL AGREEMENT

Dr. Mickler's Initial Diagnostic Interview	$175.00
Dr. Mickler's 53-minute individual psychotherapy session	$150.00
Dr. Mickler's 40-minute individual psychotherapy session	$125.00
Dr. Mickler's 20-minute individual psychotherapy session	$ 75.00
Dr. Mickler's 53-minute family psychotherapy session	$175.00

PLEASE NOTE:
Time for phone calls to coordinate care with your other providers will need to occur as part of your therapy session time (prior to the start, during or at the end of your session). If during your treatment, you need written documentation from me, this will need to occur during your session. Alternatively, additional activities that you'd prefer or that need to occur outside of the session will be billed at the rate of $150/hr. **Insurance does not cover these costs.**

PLAN A- Cash payments of fees

1.) If I file my own insurance or do not have insurance that covers psychotherapy, I will pay the full fee to Dr. Mickler on the day that services are rendered.

2.) **I AGREE TO PAY THE FULL FEE FOR MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE.** Payments must be made before or at the time of the next appointment.

3.) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Mickler for the collection of the past due account shall be my obligation as well.

PLAN B- Cash plus insurance payment of fees

I authorize the release of any medical records or other information necessary to process this claim. I also authorize any payment of medical benefits to the above referenced provider for services rendered. However, it must be fully understood that the contract is between me and my insurance company and I am fully responsible for any amount not paid by my insurance.

1.) **I will submit to the office my co payment on the day of my session**. Dr. Mickler will file my insurance and any insurance payments received are to be deducted from the balance of my account.

2.) The office does not guarantee that my insurance company will pay. They will make every attempt at the beginning of my health care to receive verification of my policy and what it covers. However, if for some reason, my insurance claim is denied, or payments are requested to be refunded, I am responsible for the full amount of my bill.

3.) The office will not enter into a dispute with my insurance company regarding my claim. This is my responsibility and obligation.

4.) I will pay the percentage of my responsibility as I continue (e.g. if my insurance pays 80% of my care, I will pay 20% of each office visit).

5.) **I AGREE TO PAY THE FULL FEE FOR ALL MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE**. Payments must be paid before or at the time of the next appointment.

6.) If I do not honor this financial agreement and develop an outstanding balance, I will pay all charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive my rights to confidentiality for purpose of the said collection fee. Any reasonable attorney fees and costs incurred by Dr. Mickler for the collection of the past due account shall be my obligation as well.

I understand and agree with all of the above office policies. I will pay today by: CASH CHECK CREDIT CARD

_____ Plan A or B _____
Signature Date

NEW PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____ Age: _____ Sex: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Phone (home) _____(work) _____ (cell) _____

Are there any phone restrictions? _____

Can we leave a message at **home**? ☐ Y ☐ N **work?** ☐ Y ☐ N **cell?** ☐ Y ☐ N

Occupation _____ Satisfaction Level _____

Driver's License # _____

Reason for Visit _____

Personal

Marital Status ☐ Single ☐ Live in Partner ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed

Partners Name _____ Age ____ Occupation _____ Employer _____

Emergency Contact Person _____ Phone _____

Relationship to Patient _____

Student Status ☐ Full Time ☐ Part Time ☐ None -School Name_____

Permanent Home Address_____

Medical

Referred by _____ Phone _____ Primary Care Physician _____

Are you presently seeing a therapist or counselor? ☐ Y ☐ N Name _____

Have you seen a Psychiatrist in the past 12 months? ☐ Y ☐ N Name _____

Current and Past Medical Conditions _____

Current Medications _____

Insurance Information

Primary _____ Policy Holder _____ DOB _____

Policy # _____Group#_____ Relationship to insured _____

CLIENT INTERVIEW

Name:	Date : Age:
Name of person completing this form, if different than client:	

Please list the reasons/concerns that brought you here today.

_____

_____

_____

Completion of the following information will provide a thorough background in better understanding your concerns.

EDUCATIONAL/OCCUPATIONAL HISTORY

What is the highest level of education you achieved? (i.e. GED, high school diploma, BS, PHD) _____

From what institution (i.e. school, university). did you receive your highest degree?

_____

Are you currently in school? (circle one) YES NO

*If yes, where and what grade/year*_____ _____

Are you currently employed? (circle one) YES NO

If yes, please describe your position and work _____

_____

If yes, how satisfied are you with your current employment?_____

Please indicate your history of previous employment

Positions ***starting with most recent***	**Month and Year**
	From: To:
	From: To:
	From: To:

Did you have any significant academic, behavioral or social difficulties growing up?

(circle one) YES NO

*If yes, please describe*_____

_____

_____

FAMILY HISTORY

List everyone with whom you currently live.

_____

How would you describe your relationship with each of these people?

(1) _____

(2) _____

(3) _____

(4) _____

The following is a checklist of characteristics or conditions that may run in families. Please put an X in the column if any of your family member(s) have or have had each characteristic or condition. If more than one brother or sister has or has had one of these characteristics or conditions, put an X for each one in the appropriate column (for example, if there were two brothers who had trouble with learning how to read, you would put two X's next to that item under the column "Brother(s)."). The "Others" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	Mother	Father	Brother(s)	Sister(s)	Others (specify)
Hyperactive/Attention problems					
Learning difficulties (reading/writing/math)					
Held back in school (retained in a grade)					
Speech problems					
Behavior problems					
Mental Retardation					
An honor student					
Legal problems due to conduct					
Depression or manic depression					
Drug or alcohol problems					
Tics, movement disorders					
Obsessive Compulsive Disorder					
School avoidance, phobias, panic attacks					
Eating Disorder					
Chronic or significant health problems					

Please describe any positive responses in as much detail as possible below (use the back of page, if necessary):

_____

_____

_____

Father: Name: _____Marital Status: Single/Married/Divorced/Widowed/Remarried

Father's present age _____ School level/Occupation_____

Mother: Name: _____Marital Status: Single/Married/Divorced/Widowed/Remarried

Mother's present age _____School level/ Occupation_____

Siblings: please circle brother or sister

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Additional family members (including adult children or close, extended family):

Name: _____Present age _____ School level/Occupation_____

Name: _____Present age _____ School level/Occupation_____

NOTE: If you do not live with your family of origin (i.e. parents, brother, sister, adult children), please describe your current relationships with them: _____

_____

MEDICAL HISTORY

Please rate your overall health (excellent, good, fair, poor)_____

Please list any history of chronic illness, hospitalizations, accidents/injuries/head injuries, loss of consciousness (date and nature of each)_____
_____
_____

If you take medications, who is your prescribing physician? _____

Please describe your habits:

Do you use nicotine? _____ If so, how much (#cig./pack per day)_____
Do you use alcohol? _____ If so, how much (#drinks per day/week/month)_____
Do you drink caffeine (tea, coffee, cola)? _____ If so, how much (#8oz. cups/day)_____
Do you use illicit substances? _____ If so, what, how much, and how often_____
_____

Please list any history of developmental difficulties (including any history of problems during your mother's pregnancy with you, complications following your birth, problems meeting your milestones such as walking or talking, or history of chronic ear infections as child)_____
_____
_____

PSYCHOSOCIAL HISTORY

How would you describe your relationships with other people at school/work, at social gatherings, in the neighborhood, etc? (i.e. close, pleasant, awkward, distant, tense):_____

How many close friends do you have and how often do you socialize with friends?_____

_____

Have you experienced any recent events you would consider especially stressful (i.e. health problems, job changes, moving, relationship difficulties, etc.).? (circle one) YES NO

*If yes, please describe*_____

_____

Have you ever experienced any events you would consider *traumatic or life endangering* (i.e. tornado, fire, abuse, etc.).? (circle one) YES NO

*If yes, please describe*_____

_____

Describe your *general* mood over the last few months. (Any ongoing difficulty with crying spells, seeming sad, anxious, unhappy or depressed?)

_____

Do you have any of the following sleep problems:

	NO	YES	*If yes, please indicate duration and nature of problem including* **how often (____times/night, ____times/week).**
Can't fall asleep			
Wake up in the middle of the night			Usual time(s) of arousal:
Wake up too early in the morning (When: am)			
Restless sleeper (move around excessively during sleep)			
Very hard to wake up			
Nightmares			
Snore			
Fall asleep or get drowsy at school/work			

Describe your energy level. _____ Describe your appetite. _____

Has your appetite changed recently? Have you gained or lost a significant amount of weight recently?

_____

How satisfied are you with your weight and appearance? (Use back of page if necessary)_____

_____

Have you had feelings of hopelessness in the last few months? (circle one) YES NO
Have you had any thoughts about harming yourself or others? (circle one) YES NO

*If yes to either above, pleaseexplain*_____

Have you had any experience with prolonged (a day or more) periods of intense energy, which may include a significant decrease in sleep, feeling much more talkative or restless than usual, starting many projects at once?
(circle one) YES NO

Have you had any experience with prolonged (a day or more) periods in which you engage in more risk-taking behavior (i.e. hypersexed, spend large amounts of money) than is typical? Or feel extremely grand, powerful?
(circle one) YES NO

*If yes to either above, please explain*_____

Have you been troubled by seeing or hear things you know are not real? (circle one) YES NO

If yes, please explain _____

Have you had episodes of significant anxiety or worries? (circle one) YES NO
Have any had any significant difficulties with fears or phobias? (circle one) YES NO

If yes to either above, please explain _____

_____

Have you had any legal difficulties (i.e. arrests, probation, etc.)? (circle one) YES NO

*If yes, please describe*_____

Do you now or have you ever engaged in any self-harming behaviors? (circle one) YES NO

*If yes, please describe nature and frequency*_____

_____

Have you ever been evaluated for any academic, behavioral, emotional or social difficulties in the past?
(circle one) YES NO

Have you ever participated in individual, family or group counseling? (circle one) YES NO

If yes to either, when, with whom, and what was the outcome of this? _____

_____

_____

What do you consider to be your strengths?_____

_____

Do you have any religious or spiritual beliefs or practices? If so, please describe _____

_____

Please list any strong interests/hobbies (i.e. what do you like to do for fun?): _____

Eating Habits Questionnaire

Name:_____ Date: _____

How satisfied are you with your appearance on a scale of 1 to 10? _____

1 = very satisfied 10 = very dissatisfied

How satisfied are you with your current weight on a scale of 1 to 10? _____

1 = very satisfied 10 = very dissatisfied

What is your current height? _____ What is your current weight? _____

What was your highest weight in the past year? _____ Lowest weight? _____

What is the most you have ever weighed? _____ When _____

What is the least you have weighed as an adult? _____ When _____

When is the last time you saw your medical doctor/nurse practitioner? _____

Are you following any particular "diet" at the current time (i.e. calorie limit, food plan, avoiding certain foods)? *Please describe*_____

Do you track calories? _____ If yes, how many do you typically eat on a normal day? _____

How often do you exercise? _____ per week/day (circle one) _____ # minutes

What kind of exercise do you do? _____

How often do you restrict your calorie intake to influence your weight? (check one)

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

How often do you use laxatives to influence your weight? (check one)

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

How often do you use diuretics (i.e. water pills) to influence your weight? (check one)

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

How often do you use diet pills or other weight loss products to influence your weight? (check one)

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

Eating Habits Questionnaire

How often do you use other substances (i.e. cocaine, amphetamines, alcohol) to influence your weight?

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

If you use substances to influence your weight, please describe_____

How often do you purge? (check one)

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

If you use substances to induce vomiting, please describe_____

How often do you binge (i.e. consume a large amount of calories in a brief period of time? (check one)

3 or > x/day_____ 3 or > x/week _____ 3 or > x/month _____ Other _____

1 –2 x/day _____ 1 – 2 x/week _____ 1 – 2 x/month _____ Never _____

What foods do you choose to binge eat? _____

Do you ever use alcohol or other substances in a way similar to binge eating? _____

Do you chew and spit out food? Yes ____ No _____

When did you begin? (approximate month/year):

Dieting/restricting _____ Using laxatives _____ Using diuretics _____

Using diet pills _____ Bingeing _____ Purging _____ Chewing/spitting food _____

Do you have difficulty with any of the following? (check any that apply)

Dizziness _____ fainting _____ racing heartbeat _____ hair loss _____

Unusual fatigue _____ frequent coldness _____ abnormal blood pressure _____

Electrolyte imbalance _____ cardiac irregularities _____ extra dry skin _____

Do you have any menstrual irregularities? _____ If yes, please describe_____

Have you ever stolen food or other items? _____

Do you spend money in a way that feels compulsive or out of control? _____

Any additional comments: