Patient Name:_____ DOB:____ /____ /____ Date: :____ /____ /____

_____
_____
Home Address Apt# City
State Zip

_____
_____
Phone Number Cell Number Work Number E-mail address

Do you prefer to be contacted at: (Please circle those that apply) Home Work
Cell E-mail

_____
_____
Emergency Contact Phone Number Relationship

_____
_____
Marital Status Social Security Number
Sex Age

_____
_____
Spouse/Partner/Parent/Guardian (circle) Social Security Number Age
Sex

_____
_____
Spouse/Partner/Parent/Guardian DOB (circle) Phone Number Cell Number

_____
_____
Insurance Provider Address City
State Zip

_____
_____
Insurance Phone Number ID Number Group Number

_____
_____
Name of Insured Relationship DOB of Insured

_____
_____
Address of Insured City State Zip Phone Number

_____
_____
Employer/School Name Address City State Zip Phone Number
(circle)

I hereby authorize Meghan Scears, MD and/or Living Hope Eating Disorder Treatment Center, PLLC to provide
information to insurance carriers concerning this illness as required by the insurance carrier and as defined in the
previously provided paperwork outlining Meghan Scears, MD and Living Hope Eating Disorder Treatment Center, PLLC's office policies and procedures.

I understand that Living Hope Eating Disorder Treatment Center, PLLC/Meghan Scears, MD will, as a courtesy, file claims with insurance carriers. However, I acknowledge and agree, except as provided by law, and in consideration of the service provided, that I will pay any charges which for any reason are not paid by any third party payer unless there is a specific written agreement between Living Hope Eating Disorder Treatment Center, PLLC/Meghan Scears, MD, and the patient and payer.

Signature of Patient or Guardian
Date

Health Information

Please list all current and previous medical conditions (i.e. asthma, diabetes, depression, etc)

_____
___

_____
___

_____
___

_____
___

Please list all current medications and over the counter medications and supplements

_____
___

_____
___

_____
___

_____
___

Please list all allergies to medications with reaction type and severity

_____
___

_____
___

Please list all hospitalizations, dates, and for what problem

_____
___

_____
___

_____
___

Please list all surgeries, and for what problem they were done

_____
___

_____
___

_____
___

Reason for today's visit:
_____

How did you hear about Dr. Scears and/or Living Hope?
_____

Are you married? Yes / No Are you working? Yes / No If so, where?
_____

Occupation? _____

Are you in school? Yes / No If so, where?
_____

Highest Level of Education Finished:
_____

Long-Term Plans?
_____

Who lives with you? Both natural parents Stepmother Spouse

Mother Stepfather Children

Father Adopted parents

Brother/Sisters

Roomate Alone Other

Explain:_____

Any recent life changes in your life or your immediate family?

Marriage Births

Divorce Deaths

Move to new house Loss of job

Starting new school/job Other: _____

Is there anything you would like to change about your life? _____

If yes, what?

_____

Family History:

Do any family members of the patient, alive or dead, have, or have had, any of these problems? If so, list the age of
the person and the relationship to the patient.

High Blood Pressure

_____

Diabetes

_____

Obesity

_____

Arthritis

_____

Cancer

_____

Asthma/Allergies

_____

Alcoholism/Drug Addiction

_____

Psychological Issues

_____

Depression

_____

Anxiety

_____

Suicide

_____

Heart attack/stroke before 55

_____

Migraines

_____

Seizure Disorder

_____

Birth Defects/Mental Retardation

_____

Eating Disorders

_____

Diet History:

Please list all foods and fluids eaten/drank in the last 24 hours. Please include all foods, even if eaten and then purged, and those eaten after midnight the day before yesterday.

Fluids means all water, milk, milkshakes, juice, pop, etc.

Foods Amounts Fluids Amounts

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
___

_____
___

Exercise History

In the last week, how much have you exercised?

Please list all exercise done in the last week, including length of exercise and intensity of exercise.

For example: Monday, Running, 5 miles in 20 minutes, moderate intensity, at 7 AM.
If no exercise in last week, please indicate that also.

If needed, please use space below to elaborate.

Type of Exercise Length
Intensity Time of Day

Sunday
_____

Monday
_____

Tuesday
_____

Wednesday
_____

Thursday
_____

Friday
_____

Saturday
_____