Living Hope
Eating Disorder Treatment Center

NEW PATIENT FORM (MINOR)

Meghan Scears, MD, PLLC

Today's Date: _____

GENERAL PATIENT INFORMATION

Patient Name | DOB (MM/DD/YYYY) | Age | Sex

Address | City | State | Zip

Home Phone | Cell Phone | Work Phone

Email

Preferred Contact Method (Please circle all that apply):
Home Phone Cell Phone Work Phone Email

Social Security Number

Parent/Guardian Name (circle one) | DOB (MM/DD/YYYY) | Age | Sex

Social Security Number | Home Phone | Cell Phone

Emergency Contact | Phone Number | Relationship

School Currently Enrolled In (write "N/A" if not applicable) | Highest Level of Education Completed

How did you hear about Living Hope Eating Disorder Treatment Center and/or Dr. Meghan Scears?

☐ Living Hope EDTC Website ☐ Internet Search ☐ Family Member/Friend
☐ Insurance Provider ☐ My Treatment Lender ☐ Alumni/Previous Patient
☐ Other, please specify: _____
☐ Referred by Outpatient Provider:

Name of Provider | Name of Facility | Phone

Address | City | State | Zip

INSURANCE INFORMATION

Insurance Provider	Phone Number	ID Number	Group Number

Provider Address	City	State	Zip

Policy Holder	Relationship	DOB (MM/DD/YYYY)

Policy Holder Address	City	State	Zip

Employer/School Name (circle one)	Phone Number

Employer Address	City	State	Zip

I hereby authorize Living Hope Eating Disorder Treatment Center and Meghan Scears, MD, 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, PLLC and 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

OUTPATIENT TEAM

Please list the names and contact information for the following outpatient providers for which your son/daughter have been receiving treatment. Should any of these not apply to you, please write, "N/A" or simply leave blank.

Name of **Primary Care Physician** | Name of Facility | Phone

Address | City | State | Zip

Name of **Psychiatrist** | Name of Facility | Phone

Address | City | State | Zip

Name of **Outpatient Therapist** | Name of Facility | Phone

Address | City | State | Zip

Name of **Outpatient Dietitian** | Name of Facility | Phone

Address | City | State | Zip

Name of **Other Outpatient Provider** | Name of Facility | Phone

Address | City | State | Zip

Name of **Other Outpatient Provider** | Name of Facility | Phone

Address | City | State | Zip

FAMILY HISTORY

Please list the occupations for each relative of the patient below. If one should not apply, please mark, "N/A":

Father: _____

Mother: _____

Stepfather: _____

Stepmother: _____

Please list the highest level of education for each relative listed below. If one should not apply, please mark, "N/A":

Father: _____

Mother: _____

Stepfather: _____

Stepmother: _____

Please list all siblings of the patient:

NAME	AGE	HIGHEST COMPLETED GRADE/EDUCATION	HEALTH	RESIDING CITY & STATE

Please list everyone who lives at home and their relation to the patient?

_____

_____

_____

_____

Have there been any recent life changes in the family? (mark all that apply)

☐ Marriage ☐ Births ☐ Loss of Job ☐ Move to new house

☐ Divorce ☐ Deaths ☐ New school/job ☐ Medical Diagnosis

☐ Other, please explain: _____

HEALTH HISTORY

Reason for today's visit: _____

What problem/issue(s) is your daughter/son having?

_____

_____

_____

_____

Please list all past and current medical problems, including age of onset and when/if they were resolved:

_____

_____

_____

_____

How old was the patient's mother when he/she was born? _____

Were there any issues with the pregnancy, labor or delivery? (circle one) Yes No

If yes, what were they?

_____

_____

Please describe the behavior and development of the patient for each:

Birth through 1 year: _____

3 – 6 years: _____

6 – 12 years: _____

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

_____

_____

_____

_____

Please list all current medications (over the counter and prescription) and supplements

_____

_____

_____

Please list all allergies to medications with reaction type and severity

_____

_____

_____

Please list all hospitalizations, ages, dates and reason for admission

_____

_____

_____

Please list all surgical procedures, ages, and dates

_____

_____

_____

Please indicate whether your child has received each of the immunizations below and list the dates on which they were administered:

IMMUNIZATION	RECEIVED	NOT RECEIVED	DATE ADMINISTERED
Hepatitis A			
Hepatitis B			
Polio			
Measles			
Mumps			
Rubella (German Measles)			
Varicella			
Gardasil			
DPT-Series			
Tetanus			

Do any family members of the patient, alive or deceased, have or have had, any of these problems? If so, please list the age and 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 _____

SOCIAL HISTORY

Do you think your child is sexually active? (circle one)	YES	NO	UNSURE	
If yes, do you think your child uses birth control? (circle one)	YES	NO	UNSURE	
If yes, do you think your child uses condoms? (circle one)	YES	NO	USNURE	
Do you think your child uses alcohol?	YES	NO	UNSURE	
Do you think your child smokes and/or uses tobacco products?	YES	NO	UNSURE	
Do you think your child smokes marijuana?	YES	NO	UNSURE	
Do you think your child uses other illicit drugs, or narcotics?	YES	NO	UNSURE	
Does your child have a license to drive a car?	YES	NO		
Does your child wear a seatbelt?	YES	NO	SOMETIMES	
Does your child have a license to drive a motorcycle?	YES	NO		
Does your child wear a helmet	YES	NO	UNSURE	N/A

Is your child currently employed (circle one) YES NO

If yes, where? _____ How long? _____

What are his/her main responsibilities?

_____

Has your child had a job(s) in the past? (circle one) YES NO

If yes, where? _____ How long? _____

What were his/her main responsibilities?

_____

Is your child currently enrolled in school? (circle one) YES NO

If yes, where? _____ What grade? _____

Please describe your child's behavior:

_____

How does your child do in school?

_____

_____

Pleas list any issues your child has had in school:

_____

_____

How does your child get along with others?

_____

_____

What are your child's hobbies/interests?

_____

_____

What does your child dislike doing the most?

_____

_____

Do you feel your child is currently losing weight, and/or have noticed this in the past? YES NO UNSURE

If yes, please describe and include ages:

_____

_____

Do you feel your child is currently gaining weight, and/or have noticed this in the past? YES NO UNSURE

If yes, please describe and include ages:

_____

_____

DIET HISTORY

Please list all foods and fluids consumed in the last 24 hours including food eaten after midnight the day before yesterday and indicate any items that were later purged. (Fluids means all water, milk, milkshakes, juice, soda, etc.)

FOODS	AMOUNTS	FLUIDS	AMOUNTS

EXERCISE HISTORY

Please list all exercise done in the last week, including length and intensity of each activity. If needed, please use space below to elaborate.

☐ I did not exercise over the last week.

	EXERCISE ACTIVITY	LENGTH	INTENSITY	TIME OF DAY
EXAMPLE:	Running	5 miles in 35 min.	Moderate	7 a.m.
SUNDAY:				
MONDAY:				
TUESDAY:				
WEDNESDAY:				
THURSDAY:				
FRIDAY:				
SATURDAY:				