Living Hope
Eating Disorder Treatment Center

NEW PATIENT FORM

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 | Marital Status

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

Social Security Number | Home Phone | Cell Phone

Emergency Contact | Phone Number | Relationship

Employer | Title/Position

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 you 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

HEALTH HISTORY

Reason for today's visit: _____

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, dates and reason for admission

_____

_____

_____

Please list all surgical procedures and dates

_____

_____

_____

SOCIAL HISTORY

Are you married? (circle one) YES NO If yes, for how long? _____

Are you sexually active? (circle one) YES NO

Are you currently employed (circle one) YES NO

If yes, where? _____ How long? _____

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

If yes, where? _____ What grade? _____

Who lives with you? (mark all that apply)

☐ Mother ☐ Stepmother ☐ Adopted Mother ☐ Spouse

☐ Father ☐ Stepfather ☐ Adopted Father ☐ Children

☐ Brother/Sister(s) ☐ Step Brother/Sister(s) ☐ Roommate(s) ☐ Alone

☐ Other, please explain: _____

Have there been any recent life changes for you or your immediate family? (mark all that apply)

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

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

☐ Other, please explain: _____

Is there anything that you could like to change about your life? (circle one) YES NO
If yes, what?

_____

_____

Do you currently consume alcohol? (circle one) YES NO

If yes, please list the number of days alcohol is consumed weekly, the type of alcohol consumed and the amounts consumed per week:

_____

_____

_____

If, no, have you consumed alcohol in the past? (circle one) YES NO

If yes, please list the last date alcohol was consumed: _____

Do you use tobacco products? (circle one) YES NO

If yes, please list the type of tobacco product used and the amount used daily:

_____

Do you currently use illicit drugs (including marijuana)? (circle one) YES NO

If yes, please list the number of days illicit drugs (including marijuana) are used weekly, the type of illicit drug used and the amounts used per week:

_____

_____

If no, have you used illicit drugs (including marijuana) in the past? (circle one) YES NO

If yes, please list the date of the last use for each kind of illicit drug (including marijuana) used:

_____

_____

FAMILY HISTORY

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 _____

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:				