Melrose Center

NAME:

DOB:

MR#: HCL# :

LABEL

Child Initial Assessment

ASEDI

The following information will assist our clinical staff with getting to know your child and completing the initial assessment appointment. **It is very important to fill this out as completely as possible prior to your initial appointment**. Providers may ask you to fill this out prior to being seen. Please use black ink.

Child's legal name	Preferred name	Child's date of birth	Child's age
Form completed by			Date form completed
What sex was your child assigned at birth? ☐ Male ☐ Female	Gender identity		
What pronouns should we use to refer to your child? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____			

What prompted you to schedule an Eating Disorder Assessment for your child at Melrose Center? _____

Please list the name of who referred you to Melrose Center? What is their relationship to you?

I have heard about Melrose Center from (check all that apply):

☐ Friend/Family/Neighbor ☐ Medical or Mental Health Provider ☐ Online (Facebook, website, search)
☐ Advertisement (Radio, print, billboard) ☐ School Social Worker or Counselor ☐ Other _____

LIVING SITUATION

Parent

Name		
Street address		☐ Rent ☐ Own
City, State, ZIP		
Home phone	Work phone	
Education	Occupation	

Parent

Name		
Street address		☐ Rent ☐ Own
City, State, ZIP		
Home phone	Work phone	
Education	Occupation	

Family status:

☐ Married ☐ Separated (in_____ / _____) ☐ Divorced (in_____ / _____) ☐ Never married

If separated, child's primary residence is with whom? _____

If parents are divorced or separated, how often does the child visit with the other parent? _____

Name of child's legal guardian _____

Name of child's foster parents _____

Foster parents' address _____

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Stepparent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Stepparent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Current living arrangements

- ☐ Lives with both parents (biological or adoptive) in same household
- ☐ Single parent
- ☐ Shared custody (parents in different households) primary residence _____
- ☐ Relative/guardian's home
- ☐ Other, describe _____
- ☐ Hospital
- ☐ Residential care
- ☐ Temporary housing
- ☐ Friend's home
- ☐ Hospital
- ☐ Homeless

Is your child adopted? ☐ No ☐ Yes. If yes, how old was your child at the time of adoption? _____

Is your child aware of the adoption? ☐ No ☐ Yes

FAMILY ENVIRONMENT/RELATIONSHIPS

Are any other issues seriously affecting your family of which you would like us to be aware?

_____

_____

_____

_____

Has your child ever experienced or witnessed any of the following?

- ☐ Domestic violence/abuse
- ☐ Community violence
- ☐ Sexual assault/molestation
- ☐ Emotional abuse
- ☐ Physical neglect
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Fire
- ☐ Other _____

☐ Yes ☐ No Have you or your child been involved with any of the following county resources?

- ☐ PCA (Personal Care Assistance)
- ☐ Foster care
- ☐ County social worker
- ☐ Respite care
- ☐ PACER (Parent Advocacy Coalition for Educational Rights)
- ☐ The ARC
- ☐ Developmental disorder social worker
- ☐ Other _____

☐ Yes ☐ No Does your child have a history of legal charges? Please describe.

_____

☐ Yes ☐ No Is your child currently on probation?

☐ Yes ☐ No Has your child ever been on probation?

☐ Yes ☐ No Has your child ever been court-ordered into chemical health or mental health treatment?

☐ Yes ☐ No Has your child ever had involvement with Child Protection Services (CPS)? Please describe.

_____

Name of CPS caseworker(s) assigned to family (if applicable)

☐ None reported _____

Name of guardian ad litem (GAL) or court appointed special advocate (CASA) assigned to family?

☐ None reported _____

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NUTRITION AND FEEDING

Current weight _____ Height _____ Date _____

☐ Yes ☐ No Does the child have difficulty gaining weight?

☐ Yes ☐ No Have there been past or present nutritional concerns?

☐ Yes ☐ No Has it been difficult for your child to eat at family functions, restaurants, or birthday parties?

What foods does your child avoid? _____

What help have you had in managing nutrition? (e.g., dietitian from Pediatric Home Services, nutritional consultations, primary doctor's suggestions, special formula, foods, etc.) _____

List any family (immediate/extended) medical history of feeding/eating disorders, GI disorders, food peculiarities. Include ages especially for siblings. _____

Are you having any problems managing the child's behavior related to feeding? (e.g., refusal to eat, vomiting, eating very slowly, tantrums) _____

What eating–related symptoms or behaviors does your child experience?

	Current & Frequency	Past & Frequency
Overeating/Emotional Eating/Binge eating		
Purging (self-induced vomiting)		
Restricting food / under-eating		
Compulsive or excessive exercise		
Diet pills / supplements or weight loss programs		
Hiding food		
Excessively Picky eater		
Laxative use		
Fears of food		

When did you first notice your child had a problem with eating and what was going on in their life then?

Eating Pattern (over past 1 month)

Breakfast _____

Snack (a.m.) _____

Lunch _____

Snack (p.m.) _____

Dinner _____

Snack (evening) _____

Fluid intake _____

What rules does your child follow around eating? _____

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BIRTH HISTORY

Term (# of weeks) _____ Premature (# of weeks) _____

Prenatal care? _____

Birth weight _____ Length _____

List any significant birth history (e.g., difficult delivery, use of oxygen, extended length of stay in the hospital/NICU, use of ventilator, etc.) _____

EDUCATION

☐ Yes ☐ No Does the child currently attend school or receive other school services?

If yes, Where? _____ Grade _____

Special education services _____

☐ Yes ☐ No Is your child involved in any sports or after-school activities? If yes, please explain:

MEDICAL HISTORY

Please list all of your child's medications, or bring a list with you of all prescribed, over the counter drugs, vitamins and/or herbal supplements that he/she currently takes:

☐ Yes ☐ No Does your child have any history of medical problems? If yes, please explain:

☐ Yes ☐ No Does your child have any history of surgeries? If yes, please explain:

☐ Yes ☐ No Has your child ever been hospitalized? If yes, please explain:

☐ Yes ☐ No Does your child have any known drug, environmental, or food allergies? If yes, please explain:

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MEDICAL HISTORY continued

Date of last bowel movement? _____

Has your child experienced any of the following in the past 3 months? Check all that apply.

Medical

- ☐ Lightheadedness
- ☐ Dizziness/fainting
- ☐ Chest pain
- ☐ Sensitivity to cold
- ☐ Leg cramps
- ☐ Shortness of breath
- ☐ Irregular pulse
- ☐ Heart racing
- ☐ Neck/back pain
- ☐ Excessive sweating
- ☐ Blueness of lips/fingers
- ☐ Chronic pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel problems
- ☐ Stomach problems
- ☐ Trouble swallowing
- ☐ Appetite change
- ☐ Heartburn
- ☐ Cough
- ☐ Vomiting blood
- ☐ Dry mouth
- ☐ Visual disturbances

Mood

- ☐ Depressed mood/unhappy
- ☐ Little interest or pleasure in most activities
- ☐ Appetite or weight changes
- ☐ Trouble falling asleep
- ☐ Waking up in the middle of the night
- ☐ Sleeping too much
- ☐ Fatigue
- ☐ Feelings of worthlessness/guilt
- ☐ Problems concentrating
- ☐ Problems making decisions
- ☐ Thoughts of death
- ☐ Too much energy
- ☐ Impulsive behaviors
- ☐ Have gone days without sleeping

Anxiety

- ☐ Worry about a number of things
- ☐ Feel anxious majority of the time
- ☐ Difficult to control the worry
- ☐ Anxiety or fear in social situations
- ☐ Fear others are judging them
- ☐ Worry they will embarrass themselves
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Feeling restless
- ☐ Obsessive thinking
- ☐ Rituals to lower anxiety
- ☐ Nightmares
- ☐ Intrusive memories/ flashbacks
- ☐ Avoid people or places that bring up memories

☐ Yes ☐ No Has your child ever contemplated suicide in the past or ever engaged in any kind of self-harm behavior (suicide attempt or self-harm)? If yes, please explain:

_____

_____

☐ Yes ☐ No Has your child ever talked with a psychologist, therapist, counselor, chaplain or other professional about emotional or personal concerns? If yes, please complete the following:

Reason for treatment	Setting (inpatient/outpatient)	Dates	Who did they talk to?

☐ Yes ☐ No Do you have any other concerns about the child's behavior at home or school? If yes, please explain:

_____

_____

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Place an “X” in appropriate boxes to identify all illnesses/conditions in your child’s blood relatives:

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Depression								
Chronic/General anxiety								
Bipolar/manic depression								
Schizophrenia/psychosis								
Eating disorder								
Psychiatric hospitalization								
Alcohol/drug abuse								
Suicide/suicide attempt								
Phobias/Fears								

What are your child’s weak areas? _____

What are your child’s strengths? _____

Does your child have friends? _____

What does your child do for fun? _____

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your child’s service preferences:

Please indicate your child’s ethnicity or cultural identification: _____

Is there anything else you feel it is important for us to know right now? _____

What do you want to achieve with eating disorder treatment for your child and family? _____

Signature of person filling out the form	Printed name	Date