Adult Clinical History

Confidential. Please complete as fully as you are comfortable before your first appointment.

ADE, Inc.
Dr. Martha H. Ireland
165 Topside E.
Hardeeville, SC 29927
(703) 722-2324 | info@irelandphd.com

> *Some of these questions are personal and a few may be difficult to answer on paper. Fill in what you can. Anything you would rather discuss in person, mark 'prefer to discuss' and leave the rest blank. Nothing here replaces conversation with Dr. Ireland.*

NAME | DATE OF BIRTH | AGE | TODAY'S DATE

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN | PHONE | DATE OF LAST MEDICAL EVALUATION

PRESCRIBING PROVIDER, IF DIFFERENT | DATE OF NEXT SCHEDULED APPOINTMENT

Current Medications, Supplements, and Vitamins

MEDICATION	DOSE AND FREQUENCY	STARTED	REASON FOR TAKING

ALLERGIES OR ADVERSE DRUG REACTIONS | PRESCRIBED BY

Hospitalizations and Higher Levels of Care

Include medical, psychiatric, and eating disorder admissions.

FACILITY	MONTH / YEAR	REASON	LENGTH OF STAY

Do you have any chronic medical conditions? ☐ Yes ☐ No

IF YES, PLEASE LIST

Do you have diabetes? ☐ Yes ☐ No

IF YES, TYPE, DATE OF DIAGNOSIS, AND CURRENT MANAGEMENT

Are you currently pregnant, postpartum, or trying to conceive? ☐ Yes ☐ No

DESCRIBE ANY OTHER IMPORTANT MEDICAL HISTORY, ONGOING SYMPTOMS, OR HEALTH CONCERNS

EATING, WEIGHT, AND BODY IMAGE

This section is the core of Dr. Ireland's specialty. Answer what applies to you. If a question does not fit your experience, leave it blank.

Weight and Growth History

> *You may leave the weight questions blank and discuss them with Dr. Ireland instead. Some people find writing numbers down distressing, and that is a reasonable reason to skip them.*

☐ I would prefer to discuss weight history in person rather than write it here

CURRENT HEIGHT

CURRENT WEIGHT, IF YOU WISH TO SHARE

DO YOU KNOW YOUR WEIGHT?

HIGHEST ADULT WEIGHT

AGE AT THAT WEIGHT

LOWEST ADULT WEIGHT

AGE AT THAT WEIGHT

WEIGHT CHANGE IN THE PAST YEAR

OVER WHAT PERIOD OF TIME

INTENTIONAL OR UNINTENTIONAL

AGE OF YOUR FIRST DIET OR ATTEMPT TO CHANGE YOUR WEIGHT

APPROXIMATE NUMBER OF DIETS SINCE

Eating Patterns

TYPICAL NUMBER OF MEALS PER DAY

TYPICAL NUMBER OF SNACKS PER DAY

LONGEST YOU TYPICALLY GO WITHOUT EATING

Please indicate how often each of the following has applied to you over the past three months.

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Skipping meals	☐	☐	☐	☐	☐	☐
Limiting how much food you eat	☐	☐	☐	☐	☐	☐
Limiting which foods you allow yourself to eat	☐	☐	☐	☐	☐	☐
Going a full day or longer without eating (fasting)	☐	☐	☐	☐	☐	☐
Counting calories, grams, or points	☐	☐	☐	☐	☐	☐
Following rigid food rules or rituals	☐	☐	☐	☐	☐	☐
Eating in secret or hiding food	☐	☐	☐	☐	☐	☐
Eating an unusually large amount of food in one sitting	☐	☐	☐	☐	☐	☐
Feeling out of control over your eating	☐	☐	☐	☐	☐	☐
Eating past fullness to the point of discomfort	☐	☐	☐	☐	☐	☐
Feeling intense guilt or shame after eating	☐	☐	☐	☐	☐	☐

Compensatory Behaviors

These questions are asked directly because they carry medical risk. Honest answers help Dr. Ireland keep you safe.

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Self-induced vomiting	☐	☐	☐	☐	☐	☐
Laxative use to control weight or shape	☐	☐	☐	☐	☐	☐
Diuretic or water pill use	☐	☐	☐	☐	☐	☐

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Diet pills, appetite suppressants, or stimulants	☐	☐	☐	☐	☐	☐
Skipping or reducing insulin to control weight	☐	☐	☐	☐	☐	☐
Exercising to compensate for eating	☐	☐	☐	☐	☐	☐
Exercising when injured, ill, or exhausted	☐	☐	☐	☐	☐	☐
Chewing and spitting out food	☐	☐	☐	☐	☐	☐
Fasting after eating	☐	☐	☐	☐	☐	☐

TYPICAL EXERCISE TYPE AND DURATION PER DAY

DAYS PER WEEK

Do you feel anxious, guilty, or agitated if you cannot exercise? ☐ Yes ☐ No

Body Image and Preoccupation

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Weighing yourself	☐	☐	☐	☐	☐	☐
Checking your body in mirrors, photos, or by measuring	☐	☐	☐	☐	☐	☐
Avoiding mirrors, photos, or certain clothing	☐	☐	☐	☐	☐	☐
Thoughts about food, weight, or shape interfering with your day	☐	☐	☐	☐	☐	☐
Avoiding eating in front of other people	☐	☐	☐	☐	☐	☐

HOW DO THOUGHTS ABOUT FOOD, WEIGHT, OR BODY SHAPE AFFECT YOUR DAILY LIFE, WORK, OR RELATIONSHIPS?

Physical Symptoms

CHECK ANY YOU EXPERIENCE

- ☐ Dizziness or lightheadedness
- ☐ Chest pain
- ☐ Hair thinning or loss
- ☐ Acid reflux or heartburn
- ☐ Swelling in hands, feet, or face
- ☐ Difficulty sleeping
- ☐ Fainting
- ☐ Feeling cold much of the time
- ☐ Dry skin or brittle nails
- ☐ Bloating or stomach pain
- ☐ Irregular or absent menstrual periods
- ☐ Heart palpitations
- ☐ Fatigue or weakness
- ☐ Constipation
- ☐ Dental problems or enamel erosion
- ☐ Difficulty concentrating

DATE OF LAST MENSTRUAL PERIOD, IF APPLICABLE

DATE OF LAST BLOOD WORK OR LABS

DATE OF LAST EKG, IF EVER

Have you ever had a bone density scan? ☐ Yes ☐ No

IF YES, WHEN AND WHAT WERE THE RESULTS

Prior Eating Disorder Treatment

PROGRAM OR PROVIDER	LEVEL OF CARE	DATES	OUTCOME

Levels of care include outpatient therapy, nutrition counseling, intensive outpatient (IOP), partial hospitalization (PHP), residential, and inpatient or medical stabilization.

Are you currently working with a registered dietitian? ☐ Yes ☐ No

IF YES, NAME AND HOW OFTEN YOU MEET

Has a provider ever given you an eating disorder diagnosis? ☐ Yes ☐ No

IF YES, WHAT DIAGNOSIS AND WHEN

Do any family members have a history of eating disorders? ☐ Yes ☐ No

IF YES, WHO AND WHAT IS KNOWN

WHAT HAS BEEN MOST HELPFUL IN PAST TREATMENT? WHAT HAS NOT BEEN HELPFUL?

ALCOHOL, SUBSTANCE, AND NICOTINE USE

Do you currently drink alcohol? ☐ Yes ☐ No

Have you used alcohol in the past but stopped? ☐ Yes ☐ No

IF YES, WHEN DID YOU STOP

TYPE OF ALCOHOL	HOW MUCH	HOW OFTEN	SINCE WHEN

Do you currently use recreational or non-prescribed drugs? ☐ Yes ☐ No

Have you used in the past but stopped? ☐ Yes ☐ No

IF YES, WHEN DID YOU STOP

SUBSTANCE	HOW MUCH	HOW OFTEN	SINCE WHEN

NICOTINE USE

☐ Cigarettes ☐ Vaping or e-cigarettes ☐ Chewing tobacco ☐ Nicotine pouches ☐ None of these

CAFFEINE PER DAY, APPROXIMATE

ENERGY DRINKS PER WEEK

HAS ANYONE EXPRESSED CONCERN ABOUT YOUR USE?

FAMILY AND DEVELOPMENTAL HISTORY

BIOLOGICAL PARENTS

☐ Mother living ☐ Mother deceased ☐ Father living ☐ Father deceased

☐ Parents married ☐ Parents divorced ☐ Parents separated ☐ Parent remarried

WHERE DOES YOUR MOTHER LIVE?

WHERE DOES YOUR FATHER LIVE?

DO YOU CONSIDER ANYONE ELSE A PARENT TO YOU? IF SO, WHO?

Siblings, Including Yourself

FIRST NAME	AGE	RELATIONSHIP (FULL, STEP, HALF)	CURRENTLY LIVES

DESCRIBE YOUR RELATIONSHIP WITH YOUR MOTHER, BOTH GROWING UP AND CURRENTLY

DESCRIBE YOUR RELATIONSHIP WITH YOUR FATHER, BOTH GROWING UP AND CURRENTLY

Were there developmental, academic, or behavioral difficulties in your childhood? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Was there alcohol or drug use in your family that affected you? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Is there a family history of depression, anxiety, or other mental health conditions? ☐ Yes ☐ No

IF YES, WHO AND WHAT

Difficult or Traumatic Experiences

You are not required to describe anything here in detail. Checking a box is enough to let Dr. Ireland know it exists so the two of you can decide together how and when to talk about it.

☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse or assault
☐ Neglect ☐ Witnessing violence in the home ☐ Bullying
☐ Serious accident or injury ☐ Sudden loss of someone close ☐ Military or combat experience
☐ Medical trauma ☐ Other ☐ I would prefer to discuss this in person

IF YOU WOULD LIKE TO SAY MORE, YOU MAY DO SO HERE

RELATIONSHIPS, EDUCATION, AND WORK

RELATIONSHIP STATUS

- [ ] Single, never married
- [ ] Married
- [ ] Partnered
- [ ] Separated
- [ ] Divorced
- [ ] Widowed
- [ ] Living with someone

IF MARRIED OR PARTNERED, FOR HOW LONG?

PARTNER'S NAME

PARTNER'S AGE

HOW WOULD YOU DESCRIBE THIS RELATIONSHIP RIGHT NOW?

Children

NAME	AGE	RELATIONSHIP (BIOLOGICAL, STEP, ADOPTED)	LIVES WITH

LAST YEAR OF SCHOOL COMPLETED

DEGREES OR CERTIFICATIONS

CURRENT PROFESSION

Employment, Most Recent First

EMPLOYER	ROLE	YEARS

DESCRIBE YOUR CURRENT WORK ENVIRONMENT AND HOW IT AFFECTS YOU

WHO MAKES UP YOUR SUPPORT NETWORK RIGHT NOW? FRIENDS, FAMILY, COMMUNITY, FAITH, OTHERS

Do you participate in regular exercise or physical activity you would describe as healthy? ☐ Yes ☐ No

PLEASE DESCRIBE

WHAT DO YOU DO FOR ENJOYMENT, REST, OR CREATIVITY?

HOW YOU HAVE BEEN FEELING

CHECK ANY THAT DESCRIBE YOU LATELY

- [ ] Sad
- [ ] Anxious
- [ ] Depressed
- [ ] Frightened
- [ ] Guilty
- [ ] Angry
- [ ] Ashamed
- [ ] Aggressive
- [ ] Resentful
- [ ] Worthless
- [ ] Tearful
- [ ] Irritable
- [ ] Confused
- [ ] Extreme ups and downs
- [ ] Jealous
- [ ] Hopeless
- [ ] Helpless
- [ ] Numb
- [ ] Overwhelmed
- [ ] Restless

☐ Lonely ☐ Empty

DESCRIBE ANY OTHER FEELINGS YOU HAVE HAD

Have you had changes in your sleep? ☐ Yes ☐ No

IF YES, DESCRIBE (FALLING ASLEEP, STAYING ASLEEP, SLEEPING TOO MUCH)

Have you had changes in your energy or concentration? ☐ Yes ☐ No

IF YES, DESCRIBE

LIST OR DESCRIBE ANYTHING CURRENTLY GETTING IN THE WAY OF DAILY FUNCTIONING: ISOLATION, DIFFICULTY GETTING TO WORK, FINANCIAL STRAIN, CONFL

Thoughts and Experiences

- ☐ I sometimes hear voices when no one nearby is speaking
- ☐ I sometimes feel other people control my thoughts
- ☐ I sometimes feel someone is out to harm me
- ☐ None of these apply to me
- ☐ I sometimes feel that forces outside me control me
- ☐ I sometimes have the same thought repeatedly and cannot stop it
- ☐ I am sometimes unable to control my behavior

IF YOU CHECKED ANY OF THE ABOVE, PLEASE EXPLAIN

Prior Mental Health Treatment

PROVIDER OR PROGRAM	TYPE OF TREATMENT	DATES	HELPFUL? WHY OR WHY NOT

SAFETY

These questions are asked of everyone. Please answer honestly. If anything here is true for you right now, tell Dr. Ireland directly rather than waiting for your appointment.

If you are in immediate danger, call 911 or go to your nearest emergency room. For crisis support, call or text 988 (Suicide & Crisis Lifeline) or chat at 988lifeline.org.

Are you currently having thoughts of suicide? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Have you had thoughts of suicide in the past? ☐ Yes ☐ No

IF YES, WHEN

Have you ever attempted suicide? ☐ Yes ☐ No

IF YES, WHEN AND WHAT HAPPENED

Do you currently have a plan or access to means to harm yourself? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Do you currently or have you previously harmed yourself without intending to die, such as cutting or burning? ☐ Yes ☐ No

IF YES, WHEN AND HOW RECENTLY

Are you having thoughts of harming another person? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

Have you had thoughts of harming another person in the past? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

Is there a firearm in your home or otherwise accessible to you? ☐ Yes ☐ No

IF YES, HOW IS IT STORED

YOUR GOALS

WHAT DO YOU WANT TO GET OUT OF THERAPY? BE AS SPECIFIC OR AS BROAD AS YOU LIKE.

IS THERE ANYTHING ELSE ABOUT YOU OR YOUR FAMILY YOU WOULD LIKE DR. IRELAND TO KNOW THAT THIS FORM DID NOT ASK ABOUT? YOU MAY ALSO USE TH

Thank you for taking the time to complete this. It gives your first session a running start.

CLIENT SIGNATURE

DATE