RIVER OAKS HOSPITAL
The New Orleans Institute

Date Completed (by Clinician): ____________ By: ____________

REFERRING THERAPIST: ____________

Full Address: ____________ City ____________ State: ____________ Zip: ____________

Phone: ____________ Fax: ____________

PATIENT NAME: ____________

Full Address ____________ City ____________ State: ____________ Zip: ____________

Phone: ____________ Fax: ____________

Pt. Age: ____________ Pt DOB: ____________

Pt Soc Sec# ____________ Name of Insured: ____________

Type of Insurance/
Pay Arrangements ____________ Relation: ____________

Insured policy & group # ____________ Insured SS# ____________

Insured Employer: ____________ Benefits ph#: ____________

Estimated LOS: ____________ Admit Date Requested: ____________

Is Patient Curently Hospitalized? If so, since when? And where? ____________

Has pt. been at River Oaks before? If so when? ____________

Does patient have an outpatient therapist, post discharge? ____________

Does patient have a place to live, post discharge? ____________

Present Symptoms:

Current weight? ____________ Height? ____________

____ depressed mood
____ anxiety
____ panic attacks
____ sleep disturbance
____ appetite disturbance
____ inability to function
____ inability to focus
____ poor concentration
____ decreased energy
____ hopelessness
____ helplessness
____ angry/rageful
____ suicidal ideation
____ suicide plan(s)
____ past suicide attempt(s)
when? ____________
how? ____________
____ psychotic
____ other ____________
____

____ flashbacks
____ nightmares
____ isolative behavior
____ disassociative episodes
____ loss of time
____ memory loss
____ self-harming behavior
what? ____________
____
____
____ eating disorder
____ compulsive overeating
____ restricting
____ binging
____ purging
how? ____________
laxatives? ____________
____ weight gain
____ weight loss
how much? ____________
____

____ relationship problems
____ affairs
____ use of prostitutes
____ use of pornography
____ anonymous sex
____ Internet sex
____ voyeurism
____ exhibitionism
____ compulsive masturbation
____ other acting out behavior
____
____
____ alcohol/drug abuse
____ sexual identity issues
____ compulsive spending
____ compulsive gambling
____ low self-esteem/worth
____ legal issues
for what?
____
____

The New Orleans Institute Intake

TRAUMA HISTORY:

MEDICAL PROBLEMS: (Describe)

MEDICATIONS (include dosage & Schedule)

PAST TREATMENT:

Inpt Php IOP OP Tx:(circle) Provider: City/St:
(From/To:)

Inpt Php IOP OP Tx:(circle) Provider: City/St:
(From/To:)

Inpt Php IOP OP Tx:(circle) Provider: City/St:
(From/To:)

Inpt Php IOP OP Tx:(circle) Provider: City/St:
(From/To:)

SPECIAL NEEDS (diet, wheelchair, hospital bed, physical/respiratory therapy, etc.)

ADDITIONAL PERTINENT INFORMATION:

INPATIENT TREATMENT GOALS:

* Note please include or attach laboratory and EKG results on Eating Disorder Patients, when necessary.