

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	_____ flashbacks	_____ relationship problems
_____ anxiety	_____ nightmares	_____ affairs
_____ panic attacks	_____ isolative behavior	_____ use of prostitutes
_____ sleep disturbance	_____ disassociative episodes	_____ use of pornography
_____ appetite disturbance	_____ loss of time	_____ anonymous sex
_____ inability to function	_____ memory loss	_____ Internet sex
_____ inability to focus	_____ self-harming behavior	_____ voyeurism
_____ poor concentration	_____ what? _____	_____ exhibitionism
_____ decreased energy	_____	_____ compulsive masturbation
_____ hopelessness	_____	_____ other acting out behavior
_____ helplessness	_____ eating disorder	_____
_____ angry/rageful	_____ compulsive overeating	_____
_____ suicidal ideation	_____ restricting	_____ alcohol/drug abuse
_____ suicide plan(s)	_____ bingeing	_____ sexual identity issues
_____ past suicide attempt(s)	_____ purging	_____ compulsive spending
_____ when?	_____ how?	_____ compulsive gambling
_____ how?	_____ laxatives? _____	_____ low self-esteem/worth
_____ psychotic	_____ weight gain	_____ legal issues
_____ other	_____ weight loss	_____ for what?
_____	_____ how much?	_____
_____	_____	_____

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.
