Appointment Form

Welcome! Please complete this form to let me know what you're seeking help for.

Name: _____ Date of birth:_____

Address: _____

Phone number (cell/mobile): _____ Phone number (home):_____

1. What is the main problem you're seeking help for?

2. Are you worried about how you look? _____Yes _____No

If you answered yes to question 2, please answer questions 2a – 2f:

2a. Please describe your appearance concerns:

2b. What are the body areas you don't like?

2c. How many hours would you estimate you spend each day thinking about your appearance? (Add up all the time you spend each day):

2d. How much emotional distress do your appearance concerns cause you? (circle one)

Mild Moderate Severe Extreme

2e. How much do your appearance concerns interfere with your functioning and quality of life? (circle one):

Mild Moderate Severe Extreme

2f. Please describe how your body image concerns affect your life:

3. Are you worried about your weight? _____Yes _____ No

If you answered yes, please answer questions 3a and 3b:

3a. Please describe your weight concerns:

3b. Is weight your most distressing body image concern? _____Yes _____No

4. What are your height and weight? Height _____ Weight _____

5. Are you worried that you smell bad? _____Yes _____No

If you answered yes to question 5, please answer questions 5a – 5e:

5a. Please describe your body odor concerns:

5b. How many hours would you estimate that you spend each day thinking about your body odor? (Add up all the time you spend each day):

5c. How much emotional distress do these concerns cause you? (circle one):

Mild Moderate Severe Extreme

5d. How much do your body odor concerns interfere with your functioning and quality of life? (circle one):

Mild Moderate Severe Extreme

5e. Please describe how your body odor concerns affect your life:

6. Are you seeking help for other types of obsessions, repetitive behaviors, or worries? _____Yes _____No

6a. If you answered yes, please describe your symptoms:

7. Please describe any other mental health issues you'd like help with:

8. Treatment

8a. Are you currently taking any medications for mental health issues? _____Yes _____No

8b. Are you currently receiving any type of therapy or counseling? _____Yes _____No

8c. Have you ever received mental health or alcohol/drug use treatment in a facility of any kind for (for example, in a hospital or residential treatment program)? _____Yes _____No

If yes, please give the name of the facilities and approximate dates you were there:

Thank you for completing this form. You can securely send it to me by going to the home page of this website and clicking on "Log in/Register" under "Patient Portal." Then click on "I am a new client." From there, it's easy to contact me and send me the form. I'll get back to you soon.