CAMHS Eating Disorder Intake Assessment Form

Patient Details:		
Name		
Address		
Date of Birth	MRN Number	Date of assessment
Assessed by	CAMHS Team	
Present at assessment e.g., parents, young person.		

Please select if the following have been discussed and/or obtained:		
Consent forms signed by parent/ guardian:	Yes ☐ No ☐	If No give details:
Introduction to CAMHS and explanation of assessment process	Yes ☐ No ☐	If No give details:
Limits of confidentiality – including risk and child protection (Children's First)	Yes ☐ No ☐	If No give details:
Attendance Policy:	Yes ☐ No ☐	If No give details:
Data Protection explained:	Yes ☐ No ☐	If No give details:

Name: Date of Birth:

Family			
Parent(s)/Guardian(s) Name(s)	Age(s)	Occupation	Relationship to Young Person
Sibling(s) name(s)	Age(s)	School/Occupation	Relationship to Young Person

Reason for Referral
Young Person's understanding of attending for assessment.
Parent(s)/Guardian(s) and young person's expectations of the service.

Social History:
Interests/hobbies/Likes & dislikes:
Friendships:
Personality:
Drugs/Alcohol Use/Forensic (any trouble with authority):

Name: Date of Birth:

Presenting Concerns

*Prompts: Duration – onset and course, severity/frequency, precipitating factors, effects on life, describe 24 hours in a typical day, *any changes from baseline?, strategies used to help, impact on functioning?*

Parent(s)/Guardian(s):

Young Person:

Current Physical Symptoms

Prompt: Menstruation, breathlessness, fatigue, insomnia, downy hair growth, dizziness/fainting, hair loss, discolouration of the skin, swelling, constipation.

Medical History

Prompt: any medical interventions, medication history.

Family dynamics/Family Relationships:

Prompt: Who is living in the family home? What support is available to the family? Who is the child close to?

What is going well at present (protective factors)

What is going well at present (protective factors)

Name: Date of Birth:

Young Person and/or Parents (separately as appropriate)

Screening of symptoms for Mental Health Disorders

History of Eating Disorder symptoms

(onset and progression, weight/eating changes, exercise, binge eating, purging, triggers, body checking, calorie counting: freq/ Intensity/fluctuation)

Impact of eating concerns on child and family functioning

Any specific medical diets or dietary preferences

(vegetarian, vegan, coeliac, diabetes, allergies, religious/faith – include information about duration/course)

Name: Date of Birth:

Typical Daily Intake at present (describe portions, where meals take place, supervised/unsupervised)			
Time	**Food & Fluid**	**Amount Eaten**	**Location +/- supervision**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Fluid			

Name: Date of Birth:

Pre-morbid eating pattern
(Typical Breakfast, lunch and dinner prior to onset, meals supervised or unsupervised, food likes and dislikes, favourite food)

Family History of eating patterns, mealtime routines, eating disorders
(parental or sibling eating or weight concerns, history of dieting)

Feeding History
Weaning
Feeding concerns 0-4 years Prompt: history of picky eating/Pica/rumination/NG feeding and help sought
Feeding concerns 5-11 years Prompt: history of picky eating/Pica/rumination/NG feeding and help sought
Feeding concerns 12-17 years Prompt: history of picky eating/Pica/rumination/NG feeding and help sought

Name: Date of Birth:

Weight History
Any known or visible change in weight? (try to quantify weight loss e.g., clothes no longer fitting, clothes sizing)

Weight History	
History of weight loss (yes/no)	
Lowest known weight kg/mBMI	
Highest known weight kg/mBMI	
Estimated weight loss kg	
Total % Body Weight Loss	

Other concerns regarding mental health past and present.
Prompt: depression, anxiety, psychosis, mania, eating disorder, self-harm, suicidality, abuse/neglect

Name: Date of Birth:

Parents only

Family History

Prompts: history of mental health problems, physical health or illness, extended family relationships and health, significant life or family events, financial or other stressors, any history of addiction, domestic violence, abuse, any identified neurodivergence including ADHD, Dyslexia, Autism

Developmental History

Early Life.

Prompt: pregnancy, birth, any hospitalisations

Post Natal Development.

Prompt: Feeding, weaning, sleep, temperament

Milestones

Prompt: age the child crawled, spoke first word, began to walk, toilet trained. Any concerns by the public health nurse?

Name: Date of Birth:

Emotional and Social Development

Prompt: social interaction when younger, interest in other children, ability to regulate, sensory differences

Educational History (including preschool)

Prompt: separation, transitions, difficulties, any current or previous school supports?

Trauma History (abuse/neglect/other)

Stressors this past year in the family

Previous Interventions

Prompt: Other services currently or previously attended re mental health, any input from OT/SLT services or Tusla

Autism Features Present

DSM criteria available in shared drive if needed. Assessment indicated? (If yes, provide information to family on assessment pathways).

ADHD Features Present

If mental health concerns are moderate/severe assessment is unreliable at present. If ADHD is indicated in the absence of mental health concerns for CAMHS, consider scheduling a separate ADHD assessment intake following screening.

Name: Date of Birth:

Medical Exam	
General Observations	
Weight	Height
m%BMI	Weight change

BP Lying/Sitting	Heart Rate Lying
BP Standing	Heart Rate Standing
Temp	O2
Any reported physical symptoms :	

MEED Risk Assessment (Please upload full document separately)		
Total No. of:	High Risk=	Alert to High Concern=
Areas of Concerns		
Weight for Height Chart		

Name: Date of Birth:

Clinical Observations/Mental State Exam
Prompt: appearance, behaviour, interaction with parents and assessors, speech and communication, understanding, insight, motivation, mood, presence of psychotic features, apparent risk

Formulation	
Current Multiaxial Diagnosis (ICD – 10):	
Axis I (Clinical psychiatric syndromes)	
Axis II (Specific disorders of psychological development)	
Axis III (Intellectual level)	
Axis IV (medical conditions)	
Axis V (Associated abnormal psychosocial situations)	

Current concerns:
5P's: Presenting, Predisposing, Precipitating, Perpetuating, Protective

Name: Date of Birth:

Outcome		
Accepted to the service: Axis I moderate/severe MH		Yes ☐ No ☐
	Keyworker (please state):	Yes ☐ No ☐
	ICP document to be completed on file	Yes ☐ No ☐
Accepted to the service: Query ADHD		Yes ☐ No ☐
Unclear (further assessment required within CAMHS)		Yes ☐ No ☐
Discharge		Yes ☐ No ☐

Next Steps	
Safety Planning	Yes ☐ No ☐
ICP Developed	Yes ☐ No ☐
Further appointment with team member(s)	Yes ☐ No ☐
Group intervention	Yes ☐ No ☐
Further assessment within CAMHS	Yes ☐ No ☐
Further assessment outside of CAMHS (discuss file close)	Yes ☐ No ☐
Discharge with recommendations of other services/supports (discuss file close)	Yes ☐ No ☐
Discharge with no other services	Yes ☐ No ☐
Specifics/Other (please detail)	