DAWNN R. MCWATTERS, PSY.D., Licensed Psychologist

INFORMED CONSENT FOR TREATMENT AND EVALUATION

The following information is designed to help you become fully informed concerning my services. Please read this information carefully before signing and feel free to ask me any questions you might have.

Summary of services provided and professional background:

As an independent practitioner in the greater Portland, Oregon metropolitan area, I provide individual and group psychotherapy, psycho-educational services, and community outreach. I do not provide legal advice or forensic services, and do not provide assessments or recommendations in support of legal actions such as child custody, competency evaluations, lawsuits or criminal charges. Except in the event of a court order or in order to bill insurance, I do not release information to third parties unconnected with treatment. Please notify me immediately if you are involved or may become involved in a legal or criminal matter.

I have received a doctorate in clinical psychology in January 2006 from the APA-accredited School of Professional Psychology at Pacific University in Forest Grove, Oregon. I subscribe to the APA Ethical Principles of Psychologists and Code of Conduct. I am licensed in the state of Washington (#PY00003711, Active Retired) as well as in Oregon (#2195). My orientation can best be described as integrative, which means that I utilize structured techniques from traditions such as cognitive-behavioral therapy, mindfulness-based cognitive therapy, and acceptance and commitment therapy, while working toward greater self-awareness and lasting change. Philosophically, I place great importance upon our developing therapy relationship and strive to create a safe, collaborative, and respectful space. **It is important to point out that psychotherapy is not like most medical doctor visits.** Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home, and come prepared to discuss areas of difficulty during our sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant or difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have significant benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first 1-2 sessions will involve an evaluation ("initial consultation") of your needs. By the end of this initial consultation period, I will be able to offer you some impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Confidentiality:

All information disclosed in sessions and the written records pertaining to these sessions is private and **confidential** and may not be revealed to anyone without your (client's) written permission, except where disclosure is required or permitted by law. These required or permitted disclosures are described in greater detail in the Notice of Privacy Practices (see attached). Examples of such limitations to confidentiality include the following:

- Abuse or neglect: As a psychologist, it is my ethical responsibility to protect individuals from harm and I may report abuse or neglect of a child, dependent adult, or developmentally disabled person when I have reasonable cause to believe that such an incident has occurred and/or might occur in the future. One important exception to this reporting condition is if the individual who has been abused is now an adult and the abuse occurred when he/she was a child, as long as there is not reasonable cause to believe that other children are at risk. I will use my professional judgment to determine whether it is appropriate to disclose protected health information in such cases and I will discuss this fully with you in such instances.
- Possible harm to self or others: If I believe that you present a clear and substantial risk of imminent, serious harm to yourself or someone else, I may be required to take protective actions. These actions may include notifying your family or significant others listed as your emergency contacts, notifying the potential victim, or contacting police or other emergency personnel. I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care, which may include hospitalization.
- Consultation or "back-up coverage" purposes: I may participate in consultation groups compromised of licensed healthcare professionals, and from time to time I may consult with these and other relevant professionals about my work with you, in order to provide the most effective treatment. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. In addition, I occasionally may use the services of a "back-up" therapist if I am out of town or unable to deliver services (due to emergency, personal illness, etc.,) for an extended length of time. In such situations, that provider will have access to my practice records in order to ensure continuity or coordination of care.
- Treatment of minors: Occasionally, I may provide services to older adolescents (ages 16-18) experiencing conditions within the scope of my practice, most commonly binge eating or weight-related concerns. In the state of Oregon, I am allowed to provide treatment to a child who is fourteen years of age or older (or thirteen years of age or older in the state of Washington), without the consent of a parent; however, Oregon law requires that parents are involved in treatment unless there are very clear clinical reasons why they should not be involved. Since adolescents benefit from an expectation of some privacy, I will not always share specific details of what an adolescent says or does in treatment. I will share progress in treatment, and notify parents of any risks of harm.

  If you are a minor signing this document, you authorize me as your treating psychotherapist to use my best judgment to decide what information to share with your parents. It is also important to know that parents have a right to access a minor's record, regardless of custody, unless parental rights have been revoked, up until the child turns 18 years of age.
- Billing and payment purposes: If I am asked to bill an insurance plan or another third party for the services I provide you, please be aware that I am required to release information about our work that typically includes the following: a) dates of service; b) mental health diagnosis; and/or c) treatment plan. Some insurance plans may request more detailed information, such as a treatment summary or copies of your client record. You should understand that I have no control over what insurance companies do with this information once it is submitted to them.

Please be aware that if you are participating in group psychotherapy, other group members are not bound by the same ethical or legal requirements regarding confidentiality, although I do ask all group members to keep the details of our group sessions "in the group" to protect the privacy and confidentiality of others.

DAWNN R. MCWATTERS, PSY.D.
Licensed Psychologist

SERVICE AGREEMENT

Fees and Payment Policy:
My current fees are as follows:

Initial intake appointment (90791: 50-60 minutes)	$225/session
Individual psychotherapy (90834, 45 minutes)	$150/session
Individual psychotherapy (90837, 55-60 minutes)	$175/session
Group psychotherapy (90853: 90-120 minutes)	$75/session

Most sessions are 40-45 minutes in duration unless we discuss otherwise. Payment methods include check, cash, or credit card. I offer a $25 discount on the initial intake fee and a $5 discount on ongoing psychotherapy session fees for clients who pay in full at time of service ("private pay"), *as long as you do not use a credit card as method of payment or ask me to bill insurance*.

Any required co-pay, co-insurance, or deductible payments are due at the beginning of each visit. All returned checks are subject to a $20 fee. **Regardless of insurance coverage, you are ultimately responsible for your bill for my services.** Please notify me immediately if any problem arises during our work together regarding your ability to make timely payments, as you are expected to keep your account current and paid in full. If this presents a financial hardship, you are responsible for contacting me immediately to establish a payment plan. Clients with a balance of $250 or more without an established payment plan may be terminated and/or referred to another provider. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, consultation, and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.

Office hours and Cancellation policy:
Psychotherapy sessions are available by appointment only, and when we schedule an appointment together, **that time is reserved exclusively for you**. I will be charge a flat $35 fee if you fail to give at least one business day's advance notice regarding a cancellation and are not able to reschedule (if I am available) within the same week. This fee will be charged regardless of the reason for the missed session. Clients who "no-show" for an appointment (e.g. do not attend and fail to leave a message in advance, advising me of their absence) may have all future appointments immediately removed from my schedule. Please call me immediately if you realize that you have not shown for an appointment, or your appointment time may be given away to a waiting client. Individuals with frequent no-show occurrences risk being transferred to another provider for treatment. **Insurance will not pay for missed appointments.** You can leave a voicemail message by calling (503) 367-9488 regarding canceling or rescheduling your appointment. Thank you for your attention to this policy.

Telephone and Emergency Procedures:
If you need to reach me between appointments, please leave a message **(that includes your phone number)** by calling (503) 367-9488 and your call will be returned as soon as possible. Please be advised that I am not always immediately available by phone. Every effort will be made to return your call within 24 hours, with the exception of weekends and holidays, or other days my office is closed. If I am out of my office (on leave or vacation) for an extended period of time and unable to check my voicemail messages, I will designate an alternate way of reaching me or provide the name of a back-up therapist who can be contacted in emergency situations. Telephone calls will be charged on a pro-rated basis of

the usual hourly rate. This does not apply to calls concerning appointment changes, billing inquiries, or similar business, and does not apply to new clients calling for an initial phone consultation.

Please be aware that e-mail correspondence or text messages may not be confidential and I may not read such messages in a timely fashion.

If you are having a crisis or mental health emergency and need to speak to someone immediately, and are unable to reach me via telephone, please call the Multnomah County Crisis Line at (503)988-4888, go to a hospital Emergency Room, or dial 911.

<u>Acknowledgement:</u> I have read and understand my rights and responsibilities as outlined in the above Informed Consent and Service Agreement. Furthermore, by signing this form, I consent to receive psychological services to be provided by Dr. Dawnn McWatters. I have received a copy of this agreement as well as the Notice of Privacy Practices.

Client name (please print clearly): ____
Client signature: ____ Date: _____________
Parent or guardian signature (if under 18): ____
Therapist signature: ____ Date: _____________

Dawnn R. McWatters, Psy.D.

Notice of Privacy Practices

This document describes how clinical and health care information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice describes the privacy policies followed by this office and any practitioner who might provide "on-call" coverage for me, and applies to the information I have about your health and the services you receive from this office. If you have any questions or requests concerning this notice, please contact me.

I am required by current federal law, effective April 14, 2003, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to give you this notice. It will tell you about the ways in which I may use and disclose protected health information about you and describe your rights and my obligations regarding the uses and disclosure of that information.

How I May Use and Disclose Protected Health Information (PHI)
By State law and the ethics of the mental health profession, I must have your written and signed consent to use and disclose health care information for the following purposes:
For Treatment: I may disclose health care information in order to provide better clinical services, i.e.; discussing your case with your primary physician or another practitioner for consultation purposes.
For Payment: I may use and disclose health information so that services may be billed and paid by you, your insurance company or a third party.
For Routine Health Care Operations: I may use health information about you in order to run my practice. For example, I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contacts.
For using PHI in any way that is not described in this Notice.

You may revoke your Consent at any time by giving written notice. Your revocation will be effective when I receive it, but will not apply to any uses and disclosures that occurred prior to that time. If you are receiving substance abuse treatment, federal and state law require your written Authorization each time I release information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time.

Special Situations
I may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety: Based on professional judgment, I may use and disclose information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court order or subpoena, and I will use my professional judgment about the information to be disclosed.
Law Enforcement: I may release health information if required to do so in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
Family and Friends: In situations where you might not be capable of giving authorization, because you are not present or due to your incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only information relevant to the person's involvement in your care.

Additional disclosures are permitted under HIPAA regulation. These will not be made without your authorization and consent. Once information leaves my office and becomes part of any data resource beyond my control, HIPAA permits disclosure in the following circumstances:

Research: Health information about you may be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address, or other information that reveals who you are.
Military, National Security, and Intelligence: If you are a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of health information about you. HIPAA also permits the release of information about foreign military personnel to the appropriate foreign military authority.
Workers Compensation: Health information may be released for workers compensation or similar programs. These programs provide benefits for work-related injuries.
Public Health Risks: Health information may be released in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental injury, reactions to medications or problems with products.
Health Oversight Activities: Health information may be disclosed to a health oversight agency such as the Oregon State Board of Psychologist Examiners for audits, investigations, inspections, or licensing purposes. These disclosures may be

necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Other Uses and Disclosures of Health Information
This office will not disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization. You may also revoke your Authorization in writing, at any time. If you revoke your Authorization, I will not disclose any further information, but I cannot take back any disclosures already made with your permission. A separate written authorization is required for the release of information regarding HIV or substance abuse treatment. In order to disclose these types of records, I will provide a separate written release that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Protected Health Information
Right to Review Records: You have the right to review your clinical, medical and billing records. You must submit a written request to me, the designated privacy officer, in order to inspect your health information. If you request a copy of the records, I may charge a fee for the costs of copying and/or mailing the records. I may deny your request to inspect, review or copy records in certain limited circumstances, such as when I believe exposure to this information may be detrimental to your mental health. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed mental health care professional to review your request and my denial. The person who conducts this review will not be the person who denied the request, and I will comply with the outcome of the review. You do not have the right to review or copy private psychotherapy notes or information compiled in anticipation or, or for use in, a civil, criminal, or administrative proceeding.
Right to Amend: If you believe the health records about you are incomplete or incorrect, you may ask me to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, you must submit a clear statement of the requested amendment to the designated privacy contact. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask to amend information that a) I did not create; b) is not part of the health information I keep; c) you would not be permitted to review, inspect, or copy; or d) is accurate and complete.
Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures I have made of clinical information about you for purposes other than treatment, payment, and routine health care operations. To obtain this list, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). I may charge you for the costs associated with providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health care information disclosed about you for treatment, payment or health care operations. You have the right to request limits on disclosures, such as asking that I not call you at your office, or that I not communicate with family members.
Right to Request Confidential Communications: You have the right to request that I communicate with you about clinical matters in a confidential ways, such as asking that I only contact you at home.
Right to a Paper Copy of this Notice: You have the right to a paper copy of this privacy notice. Even if you have agreed to receive it electronically, you are entitled to a paper copy.
Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
Right to Be Notified if There is a Breach of Your Unsecured PHI: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised

Changes to this Notice
I reserve the right to change this privacy notice, and to make the revised notice effective for any medical or clinical information I receive in the future. I will post a summary of the current privacy notice, including its effectiveness date, in my office. You are always entitled to a copy of the notice currently in effect.
Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Dept. of Health & Human Svcs.

DAWNN R. MCWATTERS, Psy.D.
Licensed Psychologist (Oregon and Washington)

Insurance Verification Form

Please call your insurance plan or verify benefits online, prior to our first appointment. Complete all applicable portions of this form, if possible.

Name of Insured ____________________________________ (circle one) Self Spouse Parent Other

Insurance Company __________________________________Phone # __________________________

Insurance Address ____

Group # _______________________________ Identification # _________________________________

Effective date __________________________ D.O.B. of insured (if not client) ____________________

To the best of your understanding, am I "in-network" □ or "out-of-network" □ (check one)?

Please complete the following information based upon my status with your insurance plan:

Deductible Amount ______________ Met? □ No □ Yes Copay per Visit _________________

Preauthorization required? □ No □ Yes Do sessions limits exist? □ No □ Yes

Do you have secondary insurance coverage? □ No □ Yes (If so, complete the following)
Name of Insured ____________________________________ (circle one) Self Spouse Parent Other

Insurance Company __________________________________ Phone # __________________________

Insurance Address ____

Group # _______________________________ Identification # _________________________________

Effective date __________________________ D.O.B. of insured (if not client) ____________________

To the best of your understanding, am I "in-network" □ or "out-of-network" □ (check one) with your secondary plan?

Deductible Amount ______________ Met? □ No □ Yes Copay per Visit _________________

Preauthorization required? □ No □ Yes Do sessions limits exist? □ No □ Yes

DAWNN R. MCWATTERS, Psy.D.
Licensed Psychologist

New Client Questionnaire

Please provide the following information, which will help me design a treatment plan geared specifically to your needs. Answer as honestly and completely as possible. If there are any items that you don't want to answer, leave them blank and we can discuss them further during our session.

Full Name: ____DOB: ____________ Age: ___________
Home Address: ____
____

Client Contact Telephone Numbers: OK to leave message? Primary contact?

Home: ( ) ______________________________ YES ☐ NO ☐ ☐
Work: ( ) ______________________________ YES ☐ NO ☐ ☐
Cell: ( ) ______________________________ YES ☐ NO ☐ ☐

Emergency Contact: ________________________________Relationship: ____________________________
Emergency Contact Phone: ____

By whom were you referred and/or how did you learn of my services?

☐ Healthcare provider: _______________________
☐ Friend or family recommendation
☐ Insurance provider directory
☐ Psychology Today directory
☐ Google or other internet search by (list keywords used): ____
☐ Flyer or other ad at: ________________________
☐ Other: _______________________________

Please provide some additional background information, if you feel comfortable:

Race or Ethnicity	
Spiritual or religious affiliation	
Gender identity and preferred pronouns	
Sexual orientation	
Highest educational degree (if in school currently, describe)	
Employment status (if employed, provide position/title)	

Presenting Issues

Please describe why you are seeking therapy:

____
____
____
____
____
____
____

Please check all of the issues that you are experiencing currently (or in the past month):

- ☐ Distractibility
- ☐ Poor memory
- ☐ Seasonal mood changes
- ☐ Sadness or depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Thoughts of hurting others
- ☐ Self-harm behaviors
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/shame
- ☐ Chronic fatigue or low energy
- ☐ Withdrawal from others
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Social discomfort or shyness
- ☐ Perfectionism
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleeping problems
- ☐ Nightmares
- ☐ Binges or overeating problems
- ☐ Frequent diets or food restricting behaviors
- ☐ Purging (vomiting, use of laxatives, etc.) to lose weight
- ☐ Medical or health problems
- ☐ Negative body image
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Financial stressors
- ☐ Parenting problems
- ☐ Problems in sexual functioning
- ☐ Relationship problems
- ☐ Identity/role confusion
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Legal matters (including custody issues)
- ☐ Other: ______________________
  ____
  ____

To the best of your knowledge, when did your current problems begin? ______________________
____

Do you have any ideas regarding what may be contributing to these problems? _______________
____
____

What would you like to gain from individual or group psychotherapy (i.e. your goals for treatment, if known)? ____
____
____
____
____
____

Are you interested in: ☐ Brief therapy (less than 12 sessions) ☐ Short-term therapy (3-12 months) ☐ Longer term therapy (1 year or longer) ☐ Not sure/don't know

Relationship and Family History

Relationship status: ____

Do you have children? ☐ No ☐ Yes If so, list age(s) of children: ___________________________

Describe your current social support network:____
____

What words would you use to describe yourself in terms of your social style (i.e. introverted or extroverted, reserved, open, assertive, quiet, etc.)? How comfortable are you in new group/social situations?

____
____
____

List the members of your family of origin (parents and siblings), including step-parents and adoptive or birthparents, if applicable:

Name	Relationship	Age
____________________	______________	____________
____________________	______________	____________
____________________	______________	____________
____________________	______________	____________
____________________	______________	____________
____________________	______________	____________
____________________	______________	____________

If your family has a history of any medical or mental health problems, check all that apply:

- ☐ Depression
- ☐ Bipolar /Manic Depression
- ☐ Hyperactivity/ attention deficit
- ☐ Suicide
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Obsessive-compulsive
- ☐ Anger/abusive
- ☐ Schizophrenia
- ☐ Eating disorder
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Cancer
- ☐ Heart disease
- ☐ Other medical: ____________________
- ☐ Other mental health: ____________________

Please check all that apply to your family-of-origin:

- ☐ Parents legally married or living together
- ☐ Parents temporarily separated
- ☐ Parents divorced or permanently separated
- ☐ Homelessness
- ☐ Mother remarried (times: ____)
- ☐ Father remarried (times: _____)
- ☐ Multiple family moves
- ☐ Financial problems
- ☐ Violence or abuse in the home
- ☐ Parent illness
- ☐ Parent death
- ☐ Parent substance abuse

<u>Medical History</u>

Date of last physical exam: _______________ Name of current physician: ______________________

Please list any CURRENT health concerns (for which you are receiving treatment or for which you might need treatment in the future): ____
____

Are you currently taking medication (including herbal supplements)? ☐ No ☐ Yes (list below)

Name of medication	Dosage	Frequency	Prescribed by	Start Date

Are you currently participating in a weight loss program? ☐ No ☐ Yes (if so, describe)

____

____

If you are seeking help with food and weight issues: what diet programs have you participated in previously (i.e. Atkins diet, Weight Watchers), and were they successful? Why or why not?

____

____

Do you get regular physical exercise? ☐ No ☐ Yes (describe: ________________________________)

Have you ever had a head injury or experienced a loss of consciousness? ☐ No ☐ Yes

Describe any past major medical problems or surgeries (including bariatric surgery), as well as past hospitalizations: ☐ Not applicable

____

____

List any substances you are currently using (include caffeine and tobacco): ☐ Not applicable

____

Have you ever had withdrawal symptoms when trying to stop using a substance? ☐ No ☐ Yes

Have you ever had problems with work, relationships, health, or the law due to your substance use? ☐ No ☐ Yes

History of Mental Health Treatment

In the past, have you ever received mental health services or taken medication for mental health problems? ☐ No ☐ Yes If Yes, please fill out the information below, as applicable.

Yes	No	Type of treatment	When?	Provider/program	Reason for Treatment
		Outpatient counseling			
		Medication (mental health)			
		Psychiatric hospitalization			
		Drug/alcohol treatment			
		Self-help/Support groups			

Do you have any history of suicide attempts or self-harm behaviors such as cutting? If so, when did this occur? ☐ Not applicable ____

____

____

If you have participated in counseling or groups in the past, what did you like about your experience? What didn't you like about your experience? ____________________________

____

____

____

____

Is there anything else that you would like me to know about your medical or mental health history?____

____

____

____

____

EATING ATTITUDES TEST (EAT-26)

Please complete this checklist ONLY if you are seeking treatment for eating-related concerns

	Please write a check √ to the right of each of the following statements:	Always	Usually	Often	Sometimes	Rarely	Never	*Score*
1.	Am terrified about being overweight							
2.	Avoid eating when I am hungry							
3.	Find myself preoccupied with food							
4.	Have gone on eating binges where I feel that I may not be able to stop							
5.	Cut my food into small pieces							
6.	Aware of the calorie content of foods that I eat							
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)							
8.	Feel that others would prefer if I ate more							
9.	Vomit after I have eaten							
10.	Feel extremely guilty after eating							
11.	Am preoccupied with a desire to be thinner							
12.	Think about burning up calories when I exercise							
13.	Other people think I am too thin							
14.	Am preoccupied with the thought of having fat on my body							
15.	Take longer than others to eat my meals							
16.	Avoid foods with sugar in them							
17.	Eat diet foods							
18.	Feel that food controls my life							
19.	Display self-control around food							
20.	Feel that others pressure me to eat							
21.	Give too much thought and time to food							
22.	Feel uncomfortable after eating sweets							
23.	Engage in dieting behavior							
24.	Like my stomach to be empty							
25.	Have the impulse to vomit after meals							
26.	Enjoy trying new rich foods							
							Total=	

1) Have you gone on eating binges where you feel that you may not able to stop? (Eating much more than most people would eat under the same circumstances)
□ No □ Yes How many times in the last 6 months? _______

2) Have you ever made yourself sick (vomited) to control your weight or shape?
□ No □ Yes How many times in the last 6 months? _______

3) Have you ever used laxatives, diet pills, or diuretics (water pills) to control your weight or shape?□ No □ Yes How many times in the last 6 months? _______