Lewisville Family Counseling PLLC

REGISTRATION FOR PARENT COUNSELING GROUP

Parent/Caretaker's Name_____

Date of Birth_____ Relationship to person with disordered eating _____

Mailing Address_____

Phone Number_____ I give permission to call and leave a voicemail __yes __no

E-mail_____ I give permission to contact me via e-mail __yes __no

How many parents/caretakers plan to attend the Parent Counseling Group? _____

If there will be a second caretaker attending group:

Second Parent/Caretaker's Name_____

Date of Birth_____ Relationship to person with disordered eating_____

Mailing Address_____

Phone Number_____ I give permission to call and leave a voicemail __yes __no

E-mail_____ I give permission to contact me via e-mail __yes __no

Has your child/adolescent ever been formally diagnosed with an eating disorder?

_____No _____Yes (diagnosis)_____

If your child/adolescent has never been formally diagnosed, please describe the nature of the eating disorder:

_____

_____

What type of treatment is the person with disordered eating currently receiving?

_____ None
_____ Outpatient Counseling (where) _____
_____ Residential Services (where)_____
_____ Nutritionist (where) _____
_____ Dietician (where) _____

Referral Source: How did you find out about this group? _____

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