NUTRITION/EATING DISORDER QUESTIONAIRE

Have you experienced weight loss or gain of 10lbs or more in the last 6 months?	☐ YES	☐ NO
Have you experienced difficulty with your appetite?	☐ YES	☐ NO
Has your food intake decreased to less than 50% of "normal" intake in the last 3 months?	☐ YES	☐ NO
Are you satisfied with your eating patterns?	☐ YES	☐ NO
Do you ever eat in secret?	☐ YES	☐ NO
Does your weight affect the way you feel about yourself?	☐ YES	☐ NO
Have any members in your family suffered from an eating disorder?	☐ YES	☐ NO
Do you currently suffer with, or have suffered in the past from an eating disorder?	☐ YES	☐ NO

Have you experienced any of the following symptoms in the last 3 months?

☐ Poor appetite	☐ Excessive thirst	☐ Eye pain	☐ Constipation	☐ Difficulty swallowing
☐ Weight loss	☐ Numbness	☐ Dental decay	☐ Frequent sore throat	☐ Blood in vomit
☐ Weight gain	☐ Dizziness	☐ Heart palpitations	☐ Chest pain/tightness	☐ Blood in stool
☐ Abdominal pain/swelling	☐ Fainting	☐ Muscle cramping	☐ Frequent or painful urination	☐ Sensitivity to cold

Do you or have you engaged in any of the following behaviors:

Behavior/Symptom	When (circle one/both)		Date of onset	Frequency (times per day/week)
Restricting food intake	Current	Past		
Binging	Current	Past		
Self-induced vomiting	Current	Past		
Laxatives	Current	Past		
Diuretics	Current	Past		
Enemas/Suppositories	Current	Past		
Ipecac	Current	Past		
Exercise (as a compensatory behavior)	Current	Past		
Chewing and spitting	Current	Past		
Food rituals	Current	Past		
Dumping food (Gastric Bypass surgery clients only)	Current	Past		
Use of prescription medications (to impact appetite or weight)	Current	Past		
Misuse of insulin to impact weight (Diabetic clients only)	Current	Past		

Restriction: Are you intentionally limiting your intake of food? ☐ YES ☐NO

Do you restrict certain type of foods? If yes, please specify: _____ ☐N/A
Do you restrict at certain times of the day? If yes, please specify: _____ ☐N/A
Do you have a caloric limit on meals or daily intake? If yes, please specify: _____ ☐N/A
How often do you engage in restrictive behaviors? _____ ☐N/A

Binge Eating: Do you ever "uncontrollably" eat a large amount of food in one sitting? ☐ YES ☐ NO

About how many calories do you consume (can provide a range)? _____ ☐N/A
How long does an average binge episode last? _____ ☐N/A
Are there certain time of day that you binge eat? _____ ☐N/A
How often do you binge eat? _____ ☐N/A

Purging: Do you engage in any behaviors to compensate for caloric intake or control weight? ☐ YES ☐ NO

Please describe these behavior(s): _____ ☐N/A
When do you experience your strong urges to engage in these behavior(s)? _____ ☐N/A

Typical Day of Eating: Please outline what an average day of eating looks like for you.

Breakfast	
Lunch	
Dinner	
Snacks	

Food Rituals: Food rituals refer to any compulsory behaviors around food, the preparation of food, the consumption of food, or any situation involving food or eating. *Some examples are cutting food into small bites, arranging food on plate, eating food in a certain order, dissembling food items, etc.* If you engage in any food rituals, please describe:

_____

Dietary Needs: Please check all that apply.

☐ Vegetarian

☐ Vegan (note: cannot accommodate this in ED treatment setting)

☐ Lactose Intolerance

☐ Gluten Allergy (note: cannot accommodate in ED treatment without documentation of test results)

☐ Other:

☐ Other:

Weight History:

Height		
Current weight		
Weight 3 months ago		
Highest weight		Date:
Lowest weight		Date:

Overall, how would you describe your relationship with food? _____

Is there anything that you would like to change? _____

How do you feel about/perceive your body? _____

How do your food/eating patterns and behaviors impact your life?

_____

_____

Please identify at least 2 goals that you would like to work on in this program:

1.

2.

3.