Eating Disorder Questionnaire

Please only fill out this questionnaire if you have either been diagnosed with an eating disorder by a medical professional or if you believe that you may have disordered eating.

Name:____

Height:_______feet______inches Current Weight (if known):______lbs Usual Weight (if known):_______lbs

Highest Adult Weight:________lbs Date:___________ Lowest Adult Weight:_______ lbs Date:__________

How often do you weigh yourself? ☐ 1-3x/day ☐ daily ☐ weekly ☐ monthly ☐ occasionally ☐ rarely ☐ never

Do you restrict how much you eat? ☐ Yes ☐ No

How many calories do you think that you need each day?______________________________________

Do you have "safe" foods? If so, please list: ____

____

Do you have "fear" foods? If so, please list: ____

____

Have you ever binged? ☐ Yes ☐ No

Frequency: ☐ more than 3 times/day ☐ 1-3 times/day ☐ more than 3 times/week ☐ less than 1 time/week ☐ never

Have you ever purged? ☐ Yes ☐ No

Frequency: ☐ more than 3 times/day ☐ 1-3 times/day ☐ more than 3 times/week ☐ less than 1 time/week ☐ never

Do you use exercise primarily as a way to control your weight? ☐ Yes ☐ No

How often do you exercise? ☐ daily ☐ 1-3 times/week ☐ less than 3 times/week ☐ never

Have you ever/do you currently use ☐ laxatives ☐ diuretics ☐ diet pills?

Frequency (day/week):____

When did these behaviors begin for you?____

____

Are there any other eating/weight behaviors we should know about?_____________________________

____

____

Have you ever been hospitalized/admitted for treatment for an eating problem? ☐ Yes ☐ No

Please list the treatment facility/facilities name(s) and dates you were a patient/resident there:_____________

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