

# ED Evaluation Questionnaire



All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name:</b>		<input type="checkbox"/> M	<input type="checkbox"/> F	<b>Age:</b>	
<b>Your Height:</b>		<b>Mother's Height:</b>		<b>Father's Height:</b>	
<b>Brother's Height(s):</b>			<b>Sister's Height(s):</b>		
<b>Have you ever missed a period?</b>			<b>If so, for how many months?</b>		
<b>What is the earliest age you can remember having eating disorder thoughts or thoughts of disordered eating?</b>					
<b>Can you identify any significant events or precipitating factors which occurred at this time in your life?</b>					
<b>Please describe any ritualistic eating disorder behaviors you may participate in and how frequently you participate in them.</b>					
<b>Please describe or explain your current satisfaction with your body image.</b>					
<b>How would you describe your personality?</b>					
<b>What is your biggest motivating factor for recovery from your eating disorder?</b>					
<b>What is your biggest fear surrounding treatment of your eating disorder?</b>					
<b>What do you perceive as your biggest challenge in the treatment of your eating disorder?</b>					

**SELF BEHAVIOR ASSESSMENT**

Please to indicate if you have currently, previously, or never participated in any of the following behaviors. Then list dates.

Behavior	Current Use (if yes, include dates & frequency)	Past Use (if yes, include dates & frequency)	Never
Restricting intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purging/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ipecac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics/water pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misuse of prescription meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SELF PHYSICAL ASSESSMENT**

Please indicate if currently experience any of the following.

Temperature sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low body temperature	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Easy bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elevated cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High pain tolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurred vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Extreme noise sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constantly tired	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty falling asleep or staying asleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose bowel movements or diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequently sick and/or injured	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular menstrual cycle	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness/winded after climbing a flight of stairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart palpitations or chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Decreased sex drive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting spells or blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irritability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty concentrating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness or tingling of any body parts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depressed mood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elevated blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

The above information is true to the best of my knowledge.

X \_\_\_\_\_  
Patient (Signature) \_\_\_\_\_ Date \_\_\_\_\_

X \_\_\_\_\_  
Legal Guardian/Authorized Individual Signature (Required if under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

Staff: The above health history questionnaire was reviewed on \_\_\_\_\_ (date) by \_\_\_\_\_ (provider).