

Eating Disorders Questionnaire

Name: _____ Age: _____ DOB: _____

1. Do you feel fat/obese? (Yes) (No)
2. How much do you fear becoming "fat" or larger than present?
_____ Extremely Afraid _____ Slightly Afraid _____ Very Much Afraid
_____ Moderately Afraid _____ Not at all Afraid

Explain: _____

3. Height: _____ Current Weight: _____ Highest: _____ Date: _____
Lowest: _____ Date: _____
Weight 2 years ago: _____ 1 year ago: _____ 6 months ago: _____

4. Does your body size or shape disturb you?
_____ Extremely _____ Slightly _____ Very Much _____ Not at All _____ Moderately

5. How often do you binge or restrict? _____
Purge? _____

Describe an average day of bingeing or restricting? _____

What types of food do you most commonly eat? _____

6. Have you ever felt out of control when bingeing and restricting? _____

7. Have you ever felt that your eating is different than normal? (Yes) (No)

Explain: _____

8. Have you ever felt miserable or guilty after bingeing or eating? (Yes) (No)

Explain: _____

Do you feel depressed after bingeing or eating? _____

9. Do you isolate while eating? (Yes) (No)

Explain: _____

10. Do you hide food? (Yes) (No)

Explain: _____

11. Do you sneak or steal food? (Yes) (No)

Explain: _____

12. Have you attempted any of the following?

- | | |
|--|------------------|
| _____ Strict dieting | Frequency: _____ |
| _____ Vomiting | Frequency: _____ |
| _____ Laxatives | Frequency: _____ |
| _____ Diuretics | Frequency: _____ |
| _____ Vigorous Exercise | Frequency: _____ |
| _____ Fasting | Frequency: _____ |
| _____ Other methods to control weight: | _____ |

13. How does your binge eating stop?

- | | | |
|-----------------------------|----------------------------|-----------------------------|
| _____ Stomach discomfort | _____ Vomiting | _____ Run out of binge food |
| _____ Interrupted by others | _____ Until falling asleep | _____ Taking laxatives |
| _____ Other: | | |

When restricting, how do you gauge what you eat? _____

14. How long have you had problems with food? _____

15. Have you ever had other problems with eating or attempts to control your eating, which has not been covered adequately so far (i.e. spitting out food, stomach stapling, jaw wiring, intestinal bypass, substance abuse, regurgitation)? _____

16. Has there ever been a time when your feelings about yourself or your social life have changed substantially as a result of your eating behavior? _____

17. Substance Abuse History: (check items that are applicable)

	Daily (amount)	Weekly (amount)	Monthly (amount)	Last Used
Cigarettes				
Other				
Marijuana				
Cocaine/Crack				
Speed				
Barbiturates				
Heroin				
PCP				
Hallucinogens				
Tranquilizers				
Antidepressants				
Alcohol				
Valium				

18. Have you ever experienced difficulty with:

19. Impulsive spending? (Yes) (No)

20. Impulsive sex? (Yes) (No)

21. Credit card use? (Yes) (No)

22. Shoplifting/stealing? (Yes) (No)

23. Do you tend to isolate? (Yes) (No)

24. Do you experience significant mood swings? (Yes) (No)

Explain: _____

25. Have you ever thought of committing suicide? (Yes) (No) When? _____

Explain: _____

26. Have you ever attempted suicide? (Yes) (No)

If yes, how many times? _____ When? _____

If so, by what means? _____

27. Have you ever overdosed on medication? (Yes) (No)

If yes, when? _____ On what? _____

28. Have you ever tried to physically hurt yourself? (cut, hit, burn, etc.) (Yes) (No)

If yes, explain: _____

29. Have you ever been hospitalized for alcohol or drug use? (Yes) (No)

If yes, explain: _____

If yes, where? _____

When? _____

Length of stay: _____

30. Have you ever been hospitalized for an emotional or psychiatric problem? ____ Yes ____ No

If yes, explain: _____

If yes, where? _____

When? _____

Length of stay: _____

31. Have you ever been hospitalized for medical problems related to your eating disorder? (Yes) (No)

If yes, explain: _____

If yes, where? _____

When? _____

Length of stay: _____

32. Have you ever been treated for an eating disorder? (Yes) (No)

If yes, explain: _____

If yes, where? _____

When? _____

Length of stay: _____

33. Have you ever seen a therapist or counselor? (Yes) (No)

If yes, whom: _____ When: _____

34. Do you have problems sleeping? (Yes) (No)

Do you wake up during the night? (Yes) (No)

Do you wake up early and can't return to sleep? (Yes) (No)

Do you have problems waking up? (Yes) (No)

35. Do you binge or exercise during the night? (Yes) (No)
 If yes, explain: _____

36. Do you experience sadness or depression? (Yes) (No)
 If yes, explain: _____

37. Are you frequently nervous? (Yes) (No)
 If yes, explain: _____

38. Do you ever exhibit periods of anger/rage? (Yes) (No)
 If yes, explain: _____

39. Please mark how much your eating disorder interferes with the following:

	Never	Rarely	Sometimes	Often	Always
Work					
Daily Activities					
Spouse					
Family					
Friends					
Feelings about self					
Finances					
Sexual Relationships					
Health					
Other					

40. Are you currently taking any medication? (Yes) (No)
 If yes, please list: _____

41. Please mark what applies to you:

Have you experienced:

- Recurrent episodes of binge eating?
- Consumption of high caloric, easily ingested foods?
- A feeling of lack of control over eating behavior?
- Awareness that your eating pattern is abnormal?
- Depression or self-loathing after bingeing?
- Concern with body shape and weight?

During the last two years have you had any of the following lasting from a few days to a few weeks?

- Sad/blue/down in the dumps/insomnia or hypersomnia
- Low energy level or chronic tiredness
- Feelings of inadequacy, loss of self-esteem, or self-deprecation
- Decreased effectiveness or productivity at school, work, or home
- Decreased attention, concentration, or ability to think clearly
- Social withdrawal
- Loss of interest in or enjoyment of pleasurable activities
- Irritability or excessive anger
- Inability to respond with apparent pleasure to praise or rewards
- Less active or talkative than usual
- Felt slowed down or restless
- Pessimistic about the future, brooding about the past
- Feeling sorry for self
- Tearfulness or crying
- Recurrent thoughts of death or suicide

Have you experienced:

- Intense fear of gaining weight
- A disturbance of body image
- Weight loss of at least 15% of original body weight
- Absences of at least 3 menstrual cycles

During the last few months have you experienced problems with:

- Sweating
- Heart pounding/racing
- Dry mouth
- Light headedness
- Cold or clammy hands
- Dizziness
- Upset stomach
- Tingling of extremities
- Diarrhea
- Lump in the throat
- Discomfort in pit of stomach
- Hot/cold spell
- Flushing or pallor
- Frequent urination

Do you experience any of the following:

- Worrying about self or others
- Fearfulness
- Fear that something bad will happen
- Difficulty in concentrating
- Feelings of being on the edge
- Irritability or impatience
- Muscle aches
- Tire easily

Have you experienced any of the following:

- Feel the need to have things organized in a particular way and become uneasy if they are moved.
- Have a particular number of times you perform a task
- Feel the need to clean after others have done so
- Have a certain way you fold/arrange your clothes
- Wash your face or hands excessively