Eating Disorders Assessment Questionnaire

Developed by Graham Alexander

Updated April 2011

Please answer this questionnaire as accurately and as honestly as possible. Do not hurry you answers, but also do not ponder on each question for too long. The information we receive from you will be very helpful as an initial assessment of your problem and design of your treatment. The information that you provide will be kept confidential and only shared amongst members of the immediate professional team treating you. You may specify individuals you wish to exclude from having access to this document below:

	Name	Reason for Exclusion (optional)
①		
②		
③		
④		

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Director: Crescent Clinic Eating Disorders Unit
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PATIENT INFORMATION

Please complete the following details and return to your clinician before your first consultation. Please ensure that all information is accurate.

PATIENT DETAILS

Title Mr. O Mrs. O Ms. O Dr. O Other (Specify)

Patient's Surname

Patient's First Names

Date of Birth D D M M Y Y Y Y ID Number

Residential Address

Area Code ►

Postal Address

Area Code ►

Contact Details Cell Telephone

Home Tel Code Work Tel Code

Email

REFERRAL & MEDICAL PROFESSIONALS

Referring Person Tel

General Practitioner Tel

Other Drs. (Specify) Tel

Tel

MEDICAL AID DETAILS *(Please ensure that this section is fully completed and correct)*

Principal Member Full Name

Principal's Contacts Cell Number

Home Tel Code Work Tel Code

I.D. Number

Medical Aid Provider or Private O

Medical Aid No. Option

PERSON RESPONSIBLE FOR ACCOUNT

Title Mr. O Mrs. O Ms. O Dr. O Other (Specify)

Surname

First Names

Date of Birth D D M M Y Y Y Y ID Number

Residential Address

Area Code ►

Postal Address

Area Code ►

Contact Details Cell Telephone

Home Tel Code Work Tel Code

Email

(If you are on medical aid, your statement will be sent to your medical aid provider via registered post, while you will receive a copy of your statement via email, unless you specifically express delivery by some other means.)

1. WEIGHT HISTORY

Current Weight *(to 1 decimal)* ☐☐☐ · ☐ kg
Height *(to closest centimetre)* ☐☐☐ cm
Age ☐☐ yrs
Body Mass Index (FOR OFFICIAL USE) ☐☐ · ☐

Highest Weight *(to 1 decimal)* ☐☐☐ · ☐ kg
Height *(to closest centimetre)* ☐☐☐ cm
Age ☐☐ yrs
Body Mass Index (FOR OFFICIAL USE) ☐☐ · ☐

Lowest Weight* *(to 1 decimal)* ☐☐☐ · ☐ kg
Height *(to closest centimetre)* ☐☐☐ cm
Age ☐☐ yrs
Body Mass Index (FOR OFFICIAL USE) ☐☐ · ☐

* *This should reflect lowest weight relating to the eating disorder rather than short height of childhood alone.*

Your Currently Desired Weight Range *(to closest kilogram)* ☐☐☐ Kg to ☐☐☐ Kg
Body Mass Index (FOR OFFICIAL USE) ☐☐ · ☐ to ☐☐ · ☐

► Please complete the following table, for each of the applicable Age Groups indicating an accurate and realistic reflection of your weight description:

	Under-weight	Normal Weight	Chubby Weight	Over-Weight	Obese Weight	Morbidly Obese
0 – 6 years	O	O	O	O	O	O
7 – 12 years	O	O	O	O	O	O
13 – 17 years	O	O	O	O	O	O
18 – 25 years	O	O	O	O	O	O
30 + years	O	O	O	O	O	O
Since children	O	O	O	O	O	O

2. CHILDHOOD WEIGHT & BODY ATTITUDES

► How did you perceive your body when you were a young child?

Very Emaciated	Very Thin	Thin Weight	Normal Weight	Chubby Weight	Over-Weight	Obese Weight	Morbidly Obese
O	O	O	O	O	O	O	O

► When you were a young child, can you recall whether your parents/family instilled a healthy philosophy about food and exercise, as well as body image?

Yes O No O If "No", in what way do you feel you had an unhealthy philosophy imparted on you?

_____

_____

_____

► Were you ever teased in your childhood about your body?

Yes O No O If "Yes", please describe below by whom, when, and in what way:

_____

_____

_____

3. WEIGHT & BODY ATTITUDES

► Which one, in your opinion, best describes your Current Weight:

Very Emaciated	Very Thin	Thin Weight	Normal Weight	Chubby Weight	Over-Weight	Obese Weight	Morbidly Obese
O	O	O	O	O	O	O	O

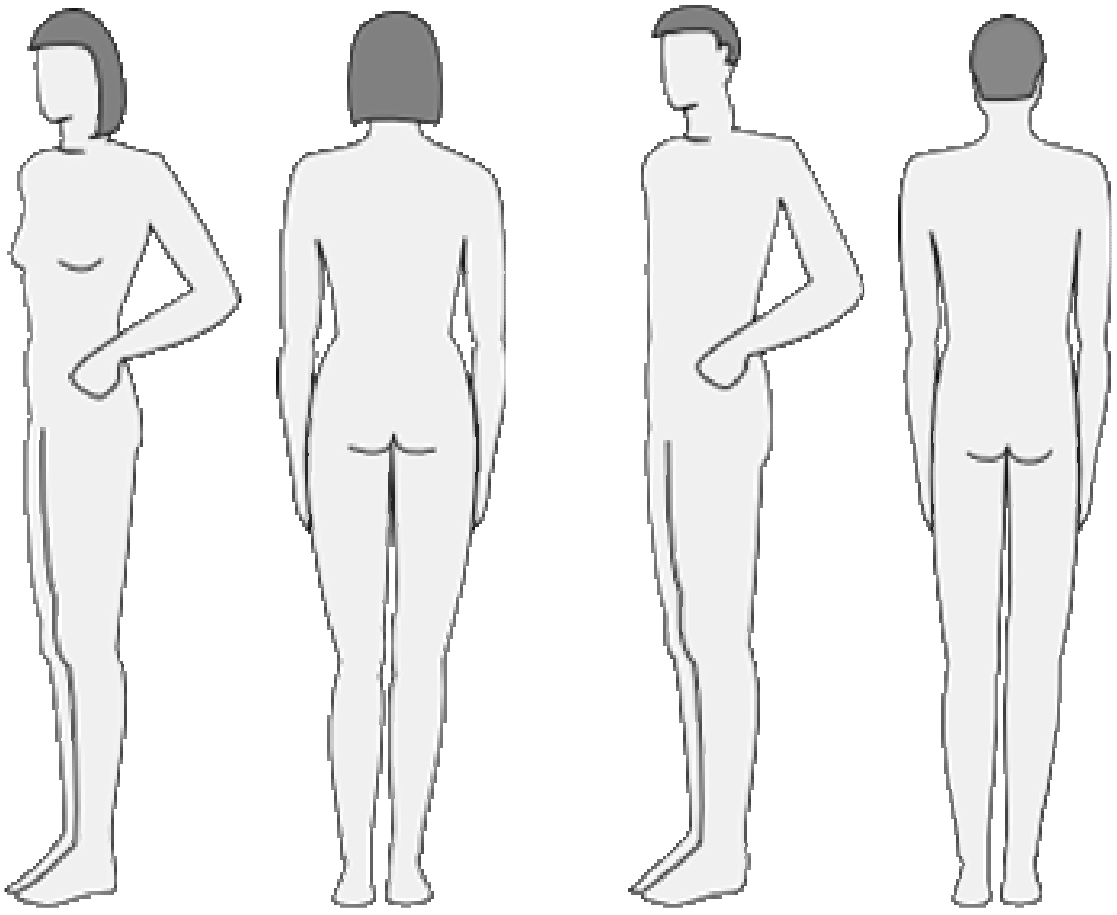
► If you were to increase 3 kilograms over the next few weeks, how would you feel?

Extremely Distressed	Very Dissatisfied	Somewhat Dissatisfied	Neutral/ Indifferent	Quite Comfortable	Pleased/ Invested	Very Pleased	Ecstatic / Delighted
O	O	O	O	O	O	O	O

► If you were to decrease 3 kilograms over the next few weeks, how would you feel?

Extremely Distressed	Very Dissatisfied	Somewhat Dissatisfied	Neutral/ Indifferent	Quite Comfortable	Pleased/ Invested	Very Pleased	Ecstatic / Delighted
O	O	O	O	O	O	O	O

► With a pen, please indicate in the relevant silhouettes below, the areas of your body that you are most dissatisfied with. Label between one and five dissatisfied body zones with circled numbers, where ① indicates your most dissatisfied body zone followed by ② representing your second most dissatisfied zone, and so forth up to a limit of ⑤ indicating your fifth most dissatisfied body zone. You can label less than five zones if you wish.



► How dissatisfied are you with the way your body is proportioned?

Not at all dissatisfied	Slightly dissatisfied	Moderately dissatisfied	Very dissatisfied	Extremely dissatisfied
O	O	O	O	O

► How important is your weight and shape in affecting how you feel about yourself as a person?

Not at all important	Slightly important	Moderately important	Very important	Extremely important
O	O	O	O	O

► How fat do you currently feel?

Not at all fat	Slightly fat	Moderately fat	Very fat	Extremely fat
O	O	O	O	O

4. DIETING BEHAVIOUR

► On the average, how often do you weigh yourself?

Never	Less Than monthly	Monthly	Several Times monthly	Weekly	Several times a week	Daily	2 or 3 times a day	4 or 5 times a day	In excess of 5 X daily
O	O	O	O	O	O	O	O	O	O

► Which meals and/or snacks do you eat on a regular daily basis? (you will likely fill in more than one circle)

Breakfast	Morning Snack	Lunch	Afternoon Snack	Supper	Evening Snack
O	O	O	O	O	O

► Have you every dieted for the purpose of influencing your weight or body shape?

No	Yes	
O	O	If "Yes", please list below the means by which you have dieted:

Skip Meals	O	Restrict Carbohydrates	O
Reduce Portions	O	Restrict Sweets, chocolates, etc.	O
Reduce Calories	O	Restrict Fats	O
Complete Fast	O	Go on Fad Diets	O

Other (specify) _____

Other (specify) _____

Other (specify) _____

► Please list the following details pertaining to any current and/or previous major diets which relate to weight loss:

	Name of diet	Weight at start of diet	Weigh at end of diet	Date and duration of diet
①		kg	kg	
②		Kg	Kg	
③		Kg	Kg	
④		Kg	Kg	
⑤		Kg	Kg	
⑥		Kg	Kg	
⑦		Kg	Kg	
⑧		kg	Kg	

► Have you ever had any significant physical or emotional symptoms while attempting to lose weight or after losing weight?

No	Yes	
O	O	If "Yes", describe the symptoms, how long they lasted, if they made you cease your weight loss programme, and if they resulted in you seeking professional support.

Problem			Year	Duration (weeks)	Stopped weight loss programme (circle)		Type of professional help
					Yes	No	
					Yes	No	
					Yes	No	
					Yes	No	

► Who or what in the past has influenced you to diet or lose weight? (you may fill in more than one circle)

Mother	O	Sports coach	O
Father	O	School culture /Societal pressure	O
Sister	O	Media	O
Brother	O	Health condition	O
Boyfriend/Girlfriend	O	Occupation (specify) ►	O

Other (specify) _____

Other (specify) _____

5. BINGE EATING BEHAVIOUR

► Do you ever eat a large amount of food in an uncontrolled way and in a short space of time?

No	O	Proceed to section 6.
Yes	O	Continue with the questions in this section.
In past	O	Continue with the questions in this sections as it pertained to the past, but answer the following question: How long ago did you cease binging? _____ years/months

► At what age did you begin bingeing? _____ years old

► How often do you currently/did you previously binge?

Multiple times A day	Once daily	Approx. 3 times weekly	Once a week	Once a fortnight	Once a month Or less
O	O	O	O	O	O

► When in the day do/did you most likely binge?

No specific time	Morning	Lunch time	Afternoon	Late evening	As long as I Am alone
O	O	O	O	O	O

► Do you binge in response to certain emotions or conditions?

Yes	No	
O	O	If "Yes", please indicate which feelings listed below you binge in response to:

Hungry ►	O	Angry ►	O	Lonely ►	O	Tired ►	O
Bored ►	O	Depressed ►	O	Sad ►	O	Fearful ►	O
Anxious ►	O	Excited ►	O	Jealous ►	O	Erotic ►	O

Please list any others ► _____ _____ _____

► Please circle the extent of the characteristic symptoms of your current or past binge eating?

①=Never ②=Rarely ③=Sometimes ④=Often ⑤=Always

Feeling that I can't stop eating or control what or how much I eat.	①	②	③	④	⑤
Eating much more rapidly or chaotically than usual.	①	②	③	④	⑤
Eating until I feel uncomfortable full and bloated.	①	②	③	④	⑤
Eating large amounts of food when aware that I am not physically hungry.	①	②	③	④	⑤
Eating in solitude because I am embarrassed of the quantity I am eating.	①	②	③	④	⑤
Feeling disgusted with myself, depressed or guilty after overeating.	①	②	③	④	⑤
Feeling very distressed about binge eating.	①	②	③	④	⑤

6. WEIGHT CONTROL BEHAVIOUR

► Have you ever resorted to any dangerous or self-destructive methods for the purpose of losing weight?

Yes O No O If "Yes", complete the remainder of this section. If "No", proceed to Section 7 now.

► Please indicate the dangerous and self-destructive method(s) of weight loss that you currently or have previously resorted to, as well as the details that pertain to each method:

Method of Weight Loss	When did you start this method?	When did you stop this method? Might be current	Extent of past use? (eg, weekly)	Current use (if applicable)
① Vomiting				
② Laxatives				
③ Diuretics (water pills)				
④ Appetite Suppressants				
⑤ Fat burners/Fat malabsorbers				
⑥ Chewing and spitting out food				
⑦ Rumination (vomiting & re-swallow)				
⑧ Excessive exercise				
⑨ Other:				
⑩ Other:				

7. EXERCISE/SPORT

► Do you currently do exercise (answer "yes") or have you done exercise in the past (answer "In past")?

No O Proceed to section 8.

Yes O Continue with the questions in this section.

In past O Continue with the questions in this sections as it pertained to the past, but answer the following question: How long ago did you stop exercising? _____ years/months

► Please list the types of exercise or sport that you do (or have done in the past), and complete the details that pertain to each form of exercise or sport:

Type of Exercise or Sport	When did you start this exercise?	When did you stop this exercise? Or is it current?	How much did you exercise this in the past?	Current weekly exercise
① Gym Aerobics (e.g., circuit, spinning)				
② Gym Anaerobic (weights)				
③ Running or jogging				
④ Walking				
⑤ Cycling (road or mountain)				
⑥ Dancing				
⑦ Field sport (e.g., hockey, rugby)				
⑧ Martial Arts				
⑨ Other:				
⑩ Other:				

8. HORMONAL AND MENSTRUAL HISTORY (MALES & FEMALES)

► For males only, have you ever been diagnosed with any hormonal abnormality?

No O Proceed to section 9.
Yes O Complete only the following table and then proceed to Section 9

► Please detail below any currently or previously diagnosed hormonal abnormality?

Diagnosis	When were you diagnosed?	When was it resolved? It might be current.	Medication required (include dose)	Treating Doctor (contact detail)
①				
②				
③				
④				

The remaining questions in this section are for females only.

► Have you ever started your primary menstruation (your first menstruation)?

No O Answer the last question in this section before proceeding to Section 9.
Yes O Continue with the questions in this section.

► Age of onset of menses? _____ years of age

► Have you ever stopped menstruating for three consecutive months or more (which were unrelated to pregnancy or contraception/hormonal treatment)?

Yes O No O If "Yes", number of times: _____

►Have your menses ever become irregular as a result of weight loss or weight fluctuation?

Yes O No O If "Yes", describe: _____

►Have you menstruated during the last three months?

Yes	No
O	O

► Please detail below any currently or previously diagnosed hormonal abnormality?

Diagnosis	When were you diagnosed?	When was it resolved? It might be current.	Medication required (include dose)	Treating Doctor (contact detail)
①				
②				
③				
④				

9. HISTORY OF ABUSE

► Have you ever experienced any form of physical, sexual, or emotional abuse?

No O Proceed to section 10.

Yes O Please try to answer the question in this section.

O I have been abused at some level, but do not feel comfortable to document this yet.

►Did you ever have any of the following happen to you (please indicate whether before and/or after the age of 18 years of age)?

	Yes	No	Before 18	After 18
① Being regularly criticised and blamed for minor things.	O	O	O	O
② Been exposed to regular verbal and or emotional abuse.	O	O	O	O
③ Being physically beaten (hit, slapped, pushed, have something thrown at you).	O	O	O	O
④ Been exposed to violence induced by alcohol and/or drugs.	O	O	O	O
⑤ Been exposed to physical violence amongst others (e.g., between parents).	O	O	O	O
⑥ Been molested by someone within your extended family (not involving intercourse).	O	O	O	O
⑦ Been molested by someone outside your extended family (not involving intercourse).	O	O	O	O
⑧ Been raped.	O	O	O	O

10. PSYCHIATRIC HISTORY

► Have you ever received any psychiatric or psychological treatment?

No O Proceed to section 11.

Yes O If "Yes", please complete the following section.

►Please list all psychiatric and psychological treatments you have are receiving or have received in the past. The "Other" rows (⑧ to ⑩) are for treatments not listed or repeat treatments.

Type of Treatment	When did it commenced	Duration of treatment	Details (e.g., facility, programme, therapist, group, medication(s)
① Psychiatric hospital inpatient admission			
② Psychiatric hospital outpatient treatment			
③ Individual psychotherapy			

Type of Treatment	When did it commenced	Duration of treatment	Details (e.g., facility, programme, therapist, group, medication(s)
④ Group therapy (professionally facilitated)			
⑤ Counselling from school psychologist			
⑥ Support group			
⑦ Psychiatric medication			
⑧ Other:			
⑨ Other:			
⑩ Other:			

►Is there any other psychological/psychiatric history of note?

11. PERSONAL MEDICAL HISTORY

►Please list all medical hospitalizations in chronological order (earliest to most recent)?

Reason for Admission	Date of admission	Duration of admission	Significant details (e.g., facility, complications, doctors names, prognosis, etc.
①			
②			
③			
④			
⑤			

►Please list all other medical treatments you have received or medical conditions that you suffer or have suffered in the past? Do not include common colds, flu, etc.

Medical treatment/Conditions/Medication	Date first treatment	Duration of condition	Significant details e.g., complications, doctors names, medication (dose), prognosis, etc.
①			
②			
③			
④			
⑤			

►Is there any other personal medical history of note?

12. SOCIAL HISTORY

► What is your highest educational qualification? _____ e.g., Grade 11, B.Sc (Geology) 2nd year, B.A. English (Hons.)

► Are you presently employed?

Yes O No O If "No", when were you last employed? _____

► Current employment or last employment if currently unemployed: _____

► How would you describe your social lifestyle? Write a few lines about your interaction with family, friends and/or intimate partners.

_____

_____

_____

_____

_____

13. CHEMICAL USE AND OTHER ADDICTIVE BEHAVIOUR

► Do you smoke cigarettes?

No O Read the next question.
Yes O If "Yes", how many cigarettes do you smoke per week on average? _____

► Have you ever used drugs or excessive alcohol, or engaged in any addictive behaviour?

No O Proceed to section 14.
Yes O Please answer the following questions in this section.

► Please document below all substances or addiction problems that you have experienced or are currently experiencing? Please also complete all the details in the table pertaining to them?

Substance/Addiction	When did you start	Duration of use (indicate if current)	Details (e.g., facility, programme, therapist, group, medication(s)
①			
②			
③			
④			
⑤			
⑥			
⑦			
⑧			
⑨			
⑩			

14 FAMILY HISTORY

► Please complete the table below, listing all members of your immediate (nuclear) family, as well as grandparents, aunts, uncles, or step-parents where applicable? Also list any other very important individual that have had a significant impact in your upbringing and development.

	Name	Age if living	Occupation/Level of education	Cause of death	Age at death
Father					
Mother					
Paternal grandfather					
Paternal grandmother					
Maternal grandfather					
Maternal grandfather					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Child					
Child					
Child					
Child					
Child					
Child					
Other:					
Other:					
Other:					
Other:					
Other:					

► Please complete the following table to indicate which, if any, family members (including extended or deceased family members) suffer or have suffered from any of the following medical or psychiatric conditions:

Family Member	Age	Condition	Age of Onset	Current Condition	Caused death	Age at death
		Depression			○	
		Bipolar Affective Disorder			○	
		Anxiety Disorder			○	
		Anorexia Nervosa			○	
		Bulimia Nervosa			○	
		Obsessive Compulsive Disorder			○	
		Alcohol Abuse			○	
		Substance Abuse (Drugs)			○	
		Other Addictions (specify)			○	
		Suicide Attempt			○	
		Obesity			○	
		Cancer			○	
		Fatal Accident (specify)			○	
		Other			○	
		Other			○	

Family Member	Age	Condition	Age of Onset	Current Condition	Caused death	Age at death
		Other			○	
		Other			○	
		Other			○	
		Other			○	
		Other			○	

15. OTHER INFORMATION

► Is there any other pertinent information that you wish to disclose?