

Eating Disorder Worksheet

Section	Subsection	Instructions	Patient Response
Personal Information	Patient's Name	Enter Full Name	
	Date of Birth	Enter Date of Birth (DD/MM/YYYY)	
	Gender	Indicate your gender identity (Male, Female, Other, Prefer not to say)	
	Contact Information	Enter primary contact phone number and email address	
Medical History	General Health History	Detail any past or current major health conditions or concerns. Do you have any allergies?	
	Mental Health History	Have you ever been diagnosed with a mental health condition? If yes, please provide details.	
	Medications	List all current medications and supplements, including dosages. Do you have any known drug allergies or intolerances?	
Family History	General Health History	Are there any major health conditions (diabetes, heart disease, etc.) in your immediate family members?	
	Mental Health History	Does anyone in your family have a history of mental health disorders (depression, anxiety, eating disorders, etc.)?	

Lifestyle	Physical Activity	<i>How would you describe your level of physical activity (Sedentary, Light, Moderate, Active, Very Active)?</i>	
	Occupation	<i>Are you currently employed or studying? If yes, please provide details.</i>	
	Sleep Patterns	<i>How many hours of sleep do you typically get each night? Do you often have trouble sleeping?</i>	
Social History	Relationship Status	<i>What is your current relationship status (Single, In a Relationship, Married, Divorced, Widowed)?</i>	
	Support Network	<i>Who do you consider part of your social support network (Family, Friends, Community Groups, Others)?</i>	
	Stress Factors	<i>Please list the top three major current stressors in your life.</i>	
Weight History	Weight 1 Year Ago	<i>What was your weight 1 year ago?</i>	
	Weight 6 Months Ago	<i>What was your weight 6 months ago?</i>	
	Current Weight	<i>What is your current weight?</i>	
	Weight Changes	<i>Have there been any significant fluctuations in your weight recently? Please describe.</i>	
Food Intake	Meal Schedule	<i>How many meals do you have per day? At what times do you typically eat?</i>	

	Eating Habits	<i>Describe your typical eating habits (e.g., types of food, portion sizes, speed of eating). Do you skip meals?</i>	
	Dietary Restrictions	<i>Do you have any dietary restrictions (allergies, intolerances, personal or religious beliefs)?</i>	
Eating Disorder Symptoms	Binging	<i>Have you ever experienced episodes of binge eating? If yes, please describe the frequency and context.</i>	
	Purging	<i>Have you ever engaged in purging behaviors (e.g., self-induced vomiting, laxative use)? If yes, please describe the frequency and context.</i>	
	Body Image	<i>How do you feel about your body? Have your feelings about your body changed recently?</i>	
	Exercise Habits	<i>What are your exercise habits? Have you noticed any changes recently?</i>	