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Eating Disorders Interview and Nutrition Evaluation

Name: _____ **Date of Evaluation:** _____

Date of Birth: _____ **Age:** _____

Diagnosis: [ ] Anorexia Nervosa [ ] Bulimia Nervosa [ ] Eating Disorder, NOS
[ ] Other _____

PMH: _____

_____

_____

Medications: _____

_____

_____

Vitamin/Mineral/Herbal Supplements: _____

_____

_____

Ht.: ___ft. ___in (___cm) Wt.: ___ # (___kg)

IBW: _____ %IBW: _____ BMI: _____kg/ _____ m^2 = _____

Nutritional Medical Concerns:

Date of last labs: _____ [ ] wnl
[ ] Hypercholesterolemia [ ] High triglycerides
[ ] Hypertension [ ] Diabetes
[ ] Other _____

Bone Density Scan

[ ] No [ ] Yes Date _____
[ ] wnl
[ ] Osteopenia
[ ] Osteoporosis

Presently experiencing any one of the following:

[ ] Hair Loss	[ ] Constipation	[ ] Fainting
[ ] Brittle Nails	[ ] Diarrhea	[ ] Dizziness
[ ] Dry, itchy skin	[ ] Cold at room temperature	[ ] Lactose intolerance
[ ] Sore throat	[ ] Lack of energy	[ ] Other _____
[ ] Food allergies _____		_____

[ ] Irregular sleep patterns [ ] Trouble getting to sleep [ ] Trouble staying asleep [ ] Naps

Approximate number of hours sleep/night: _____ Average number of hours worked per week: _____

For Women – Menstruation History:

Age first menstruated: _____ [ ] BCP
Periods of amenorrhea: _____
_____
[ ] Perimenopausal [ ] Postmenopausal
[ ] HRT

Pregnancy: [ ] Now Pregnant Week Gestation: _____
EDD: _____ Prepregnancy Wt: _____ # (kg)
BMI: _____ Current Weight: _____ # Optimal Gain: _____ #
Wt. [ ] gained [ ] lost _____ # G ___P___ Ab___LC___
Problems with Previous Pregnancies: _____
_____

FAMILY WEIGHT HISTORY AND RELATIONSHIP TO FOOD/BODY SHAPE:

Family Structure: _____

Meal Time Experience: _____

Family members and others who influenced body image, weight, food intake:

[ ] Mother [ ] Father [ ] Sister(s) [ ] Brother(s) [ ] Grandparent(s) [ ] Other(s) _____

How?: _____

WEIGHT HISTORY (Eating disorder history and weight/diet history):

Highest weight since age 18..... _____ lb. at age _____ or approximate date _____

Lowest weight since age 18..... _____ lb. at age _____ or approximate date _____

Highest weight between ages 12 - 18..... _____ lb. at age _____ or approximate date _____

Lowest weight between ages 12 -18..... _____ lb. at age _____ or approximate date _____

Perception of weight/size as a child aged 6-12 years old:

[ ] Thin [ ] Average [ ] Overweight

Were you ever teased about your weight? [ ] Yes [ ] No

If yes, how teased? _____

WEIGHT/BODY IMAGE:

Frequency of monitoring weight:

[ ] Several times a day [ ] Daily [ ] Weekly [ ] Monthly [ ] Hardly ever or never

Patient's Goal Weight: _____

Thoughts if gained 2 pounds: _____

Thoughts if lost 2 pounds: _____

Percentage of day think about food? _____

Percentage of day think about body image? _____

How do you feel about your body on a scale of 1 - 5? **1 2 3 4 5**

(1 = very satisfied, 5 = very dissatisfied)

Parts of the body liked: _____

Describe "Physical Hunger" _____

Describe "Physical Fullness" _____

LIFESTYLE:

Exercise: _____

Cigarette smoking: [ ] No [ ] Yes If yes, ppd _____ How long? _____

Beverages (number cups/day):

_____ Water _____ Coffee/Tea _____ Decaf Coffee/Tea _____ Soft Drinks _____ Diet Soft Drinks

_____ Juices Other: _____

Alcohol Frequency : [ ] Infrequently or never [ ] Monthly

[ ] Weekly Number of drinks week: _____ **[ ] Daily Number of drinks day** _____

[ ] Beer [ ] Wine [ ] Other: _____

Estimated Needs/Other Notes: _____

PRESENT NUTRITIONAL INTAKE:

Person who prepares the meals: _____ Grocery shops: _____

How often orders take-out/type of food: _____

How often eats out: _____ What types of restaurant and what do you usually order?

_____

_____

24 HOUR RECALL: Day/Date: _____ Day/Date: _____

Estimated caloric intake: _____ [ ] Unable to estimate

Estimated Minimum Intake (# servings):

Dairy Protein:	**0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15**
Vegetarian/Meat Protein:	**0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15**
Fruits/Vegetables:	**0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15**
Grains:	**0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15**
Others:	**0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15**

Count Calories? [ ] Yes [ ] No If yes, calorie goal _____

Count Fat Grams? [ ] Yes [ ] No If yes, fat gram goal _____

Safe Foods: _____

_____

Not Safe Foods: _____

_____

EATING DISORDER SYMPTOMS (frequency, length of time):

[ ] Restrict _____

[ ] Binge eat _____

[ ] Self-induced vomiting _____

[ ] Chew/spit out food _____

[ ] Laxatives _____

[ ] Diuretics _____

[ ] Ipecac _____

[ ] Diet pills _____

[ ] Exercise _____

[ ] Other _____

How long does a binge or binge/purge typically last:

[ ] < 1 hour [ ] 1 - 2 hours [ ] 3 - 4 hours [ ] > 4 hours

What is the average number of times you will binge/purge at one time: _____

Is there a usual time of day? _____

Do you know what is most likely to make you binge or binge/purge? _____

_____

Description of typical Binge or Binge/purge episode: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Feeling(s) before binge or binge/purge: _____

_____

Feeling(s) after binge or binge/purge: _____

_____

Feeling(s) from restricting: _____

_____

ASSESSMENT:

TREATMENT GOALS:

RECOMMENDED PLAN:

Nutrition Counseling:
[ ] Weekly [ ] Biweekly
[ ] Other _____

Labs/Tests:
[ ] CBC
[ ] Comprehensive Metabolic Panel
[ ] Electrolytes
[ ] Other _____

[ ] Bone Density [ ] EKG

Vitamins/Minerals/Supplements:

[ ] Referral to therapist
[ ] Referral to physician
[ ] Other _____

Follow-up: _____

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