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Child/Adolescent 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) Percentile: _____ Wt.: ___# (___kg) Percentile: _____

IBW: _____ %IBW: _____ BMI: _____ kg/ _____ m^2 = _____ Percentile _____

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: _____

For adolescent female:

Age first menstruated: _____ [ ] BCP

Periods of amenorrhea: _____

_____

Estimated Needs/Other Notes: _____

_____

_____

_____

_____

FAMILY WEIGHT HISTORY AND RELATIONSHIP TO FOOD/BODY SHAPE:

Family Structure:

[ ] Parents together, lives with both parents

[ ] Parents divorced/separated, lives with:

Mother____days a week _____

Father ____days a weeks _____

Other: _____

Meal time experience _____

Food struggles within the family: _____

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): _____

Perception of weight/size:

[ ] Thin [ ] Average [ ] Overweight

Ever teased about weight? [ ] Yes [ ] No

If yes, how teased? _____

Child's/Adolescent's concerns regarding weight/food issues: _____

Parental concerns regarding weight/food issues: _____

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:

Activity/Exercise: _____

School Gym class: _____

After school: _____

Weekends: _____

_____

Beverages (number cups/day):

Water _____ Soft Drinks _____ Diet Soft Drinks _____ Juices _____ Other: _____

Coffee _____ Decaf coffee _____ Tea _____ Decaf/Herbal Tea _____

_____

Adolescents: Alcoholic Beverages:_____

Cigarettes: _____ppd

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 [ ] CMP
[ ] Electrolytes
[ ] Other_____
[ ] Bone Density [ ] EKG

Vitamins/Minerals/Supplements:

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

Follow-up:

Cheryl Craig, RD