Eating Disorder Test

Patient Information:	
Name: Mary Jane Parker	
Date of Birth: 01/01/1990	Contact Information: 555-555-5555

Instructions: Please answer each question truthfully and to the best of your ability. The results of this test can help healthcare professionals understand your relationship with food and determine if you may be experiencing symptoms of an eating disorder.

1. How often have you been preoccupied with thoughts of food, weight, or body shape over the past year?

- [x] Almost never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Almost Always

2. How often have you been avoiding certain foods or food groups because you are afraid of gaining weight?

- [ ] Almost never
- [ ] Rarely
- [ ] Sometimes
- [x] Often
- [ ] Almost Always

3. How often have you felt guilty or ashamed after eating?

- [ ] Almost never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [x] Almost Always

4. How often have you engaged in binge eating episodes where you feel like you can't control how much you're eating?

- [ ] Almost never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [x] Almost Always

5. How often have you purged (vomited or used laxatives) after eating?

- [ ] Almost never
- [ ] Rarely
- [x] Sometimes
- [ ] Often
- [ ] Almost Always

6. How often have you engaged in excessive exercise to lose weight or prevent weight gain?

- [ ] Almost never
- [ ] Rarely
- [ ] Sometimes
- [x] Often
- [ ] Almost Always

7. How often have your eating habits impacted your daily life and activities?

- [ ] Almost never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [x] Almost Always

8. Have you experienced a significant change in your weight in the past year?

- [x] Yes
- [ ] No

9. How much more or less do you worry about your weight and body shape compared to other people your age?

- [ ] A lot less
- [ ] A little less
- [ ] About the same
- [ ] A little more
- [x] A lot more

10. How afraid are you of gaining 3 pounds?

- [ ] Not afraid
- [ ] Slightly afraid
- [ ] Moderately afraid
- [ ] Very afraid
- [x] Terrified

11. When was the last time you went on a diet?

- [ ] I have never been on a diet
- [ ] Over a year ago
- [ ] 6 months ago
- [ ] 3 months ago
- [ ] 1 month ago
- [ ] Less than a month ago
- [x] I am on a diet now

12. How important is your weight compared to other things in your life?

- [ ] Not important
- [ ] A little more important
- [ ] More important than most things
- [x] The most important thing

13. How often do you feel fat?

- [ ] Almost never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [x] Almost Always

14. How many times in the past 3 months have you had a sense of loss of control while eating an unusually large amount of food?

Answer: 5

15. Have you engaged in any of the following behaviors in the past 3 months as a means to control your weight and shape?

Made yourself throw-up?	**Answer:**	Yes
Used diuretics or laxatives?	**Answer:**	Yes
Exercised excessively?	**Answer:**	Yes
Fasted?	**Answer:**	Yes

16. Do you consume a small amount of food (less than 1200 calories/day) on a regular basis to influence your shape or weight?

☑ Yes ☐ No

17. Do you struggle with a lack of interest in eating or food?

☑ Yes ☐ No

18. Do you avoid certain or many foods due to fear of negative consequences like choking or vomiting?

☑ Yes ☐ No

19. Have you experienced significant weight loss (or are at a low weight for your age and height) but are not overly concerned with the size or shape of your body?

☑ Yes ☐ No

20. Are you currently in treatment for an eating disorder?

☑ Yes ☐ No ☐ Not currently, but I have been in the past

21. Have you ever been diagnosed with an eating disorder?

☐ Yes ☑ No

22. Have you received treatment for an eating disorder in the past?

☐ Yes ☑ No

23. What was your lowest weight in the past year, including today, in kgs?

Answer: 45 kgs

24. What is your current weight in kgs?

Answer: 48 kgs

25. What is your current height in cm?

Answer: 160 cm