Eating Questionnaire

Client's name: _____ Date: _____
Form completed by: _____

Referred by: _____
If you need any more space for any of the following questions please use the back of the sheet.

Background
What prompted you/your child to schedule an Eating Disorder assessment?

_____
_____
____

What eating-related symptoms or behaviors has your child experienced?

	Current	Past
Overeating/binge eating	☐	☐
Purging/vomiting	☐	☐
Taken laxatives, diet pills or water pills, etc.	☐	☐
Under-eating/restricting food intake	☐	☐
Excessive or compulsive exercise	☐	☐
Other: __	☐	☐

Please list your child's highest and lowest weights and respective ages:
Highest weight _____ *Age at highest weight* _____
Lowest weight _____ *Age at lowest weight* _____

To your knowledge, what is the least your child has weighed at current height?
_____

How do you find your child's weight at this point? How was it before the eating disorder started? Do you know where they were on their growth chart before they got ill?
_____
_____
__
_____
__
_____
__

Mental Health
Has your child ever received therapy/counseling before? ☐ Yes ☐ No
If yes, please describe when and why:
_____

_____
__

Has your child ever been prescribed psychiatric medication (e.g. an antidepressant)? ❒ Yes ❒ No
If yes, please describe when and for what purpose psychiatric medications were prescribed:
_____
_____
__

Has your child ever attempted suicide? ☐ Yes ☐ No
Has your child ever been psychiatrically hospitalized? ☐ Yes ☐ No
Has your child ever been sexually abused? ☐ Yes ☐ No
Has your child ever been physically abused? ☐ Yes ☐ No
Has your child ever been emotionally abused? ☐ Yes ☐ No

Does your child have any present or past difficulties with impulsive behaviors (check all that apply):
❒ Shoplifting/Stealing ❒ Gambling ❒ Compulsive shopping
❒ Compulsive sexual behavior ❒ Other:

Does your child drink alcoholic beverages? ❒ Never ☐ Per day, _____ times
☐ In a week, _____ times ☐ In a month, _____ times

Does your child currently use street drugs or use any prescription drugs not as prescribed?
☐ Never ☐ Per day, _____ times ☐ In a week, _____ times
☐ In a month, _____ times

If your child has ever been concerned about his/her drinking or drug use, describe what help you/your child sought: _____
_____

Does your child smoke cigarettes or use tobacco products? ☐ Yes ☐ No

Does your child ingest caffeine? ☐ Never ☐ Per day, _____ times
☐ In a week, _____ times ☐ In a month, _____ times

Physical Health
Who is your child's primary health care provider (i.e. physician, nurse, OB/GYN)?
_____
_____
_

When was your child's last physical? _____
Has your child ever been hospitalized? ☐ Yes ☐ No
Has your child ever had surgery? ☐ Yes ☐ No

If your child is a girl, when did she start her periods? ____

When was her last period? _____

Please list any prescription medications, over-the-counter drug, vitamins, and/or herbal supplements that your child is currently taking and dosages, if known:

_____
_____
__
_____
__

Family History

Who were your child's primary caregivers growing up (i.e. who raised your child)?

_____
_____
__
_____
__

Where did your child grow up/spend most of his/her childhood?

_____

How many children are in your family of origin? _____
Where does your child fall in birth order (first, middle, etc.)? _____

What were the parent's/guardian's occupations when your child was growing up?

_____
_____
__

With whom does your child live at this time?

_____

Are parent's divorced or separated? ☐Yes ☐No
If Yes, who has legal custody?_____

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in therapy? ☐Yes ☐No
If Yes, describe:

_____
_____
_
_____
_

Client's Mother

Name: _____
Age: _____ Occupation:_____
Mother's education: _____

Is there anything notable, unusual, or stressful about your child's relationship with the mother?
☐ Yes ☐ No

If Yes, please explain: _____
_____

How is your child disciplined by the mother? _____
_____

For what reasons is your child disciplined by the mother?
_____

Client's Father
Name:_____
Age: _____ Occupation: _____
Father's education: _____
Is there anything notable, unusual, or stressful about your child's relationship with the father?
☐ Yes ☐ No

If Yes, please explain: _____
_____

How is your child disciplined by the father? _____
_____
For what reasons is your child disciplined by the father?
_____
_____
____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender

Others living in household

Name	Age	Relationship to child

Family Health History

Have any of the following diseases occurred among your child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

☐ Anxiety ☐ Depression ☐ Learning problems/disabilities ☐ Dyslexia
☐ ADHD ☐ Suicide ☐ Autism ☐ Behavior problems
☐ Bipolar/Manic-Depression ☐ Schizophrenia ☐ Substance Abuse

Childhood/Adolescent History

Pregnancy/Birth

Length of pregnancy: _____
Mother's age at child's birth: _____ Father's age at child's birth: _____
Child is number _____ of _____ total children.

While pregnant, did the mother use drugs or alcohol? ☐ Yes ☐ No
If Yes, type/amount:
_____

While pregnant, did the mother have any medical or emotional difficulties?
(e.g., surgery, hypertension, medication, depression) ☐ Yes ☐ No
If Yes, describe: _____
_____

Describe any complications with the delivery: _____
_____
_____

Describe any complications for the mother or the baby after the birth: _____
_____
_____

Infancy/Toddlerhood

Check all which apply:

☐ Vomiting ☐ Diarrhea ☐ Rashes ☐ Colic ☐ Not cuddly ☐ Cried often
☐ Rarely cried ☐ Overactive ☐ Underactive/lethargic ☐ Trouble sleeping
☐ Trouble eating ☐ Irritable

Developmental History

Please note the age at which the following behaviors took place:

Took 1st steps: _____ Tied shoe laces: _____
Spoke words: _____ Spoke sentences: _____
Toilet trained: _____ Weaned: _____
Dry during day: _____ Dry during night: _____

Compared with others in the family, child's development was:

☐ slow ☐ average ☐ fast

Education

Current school: _____

Type of school: ☐ Public ☐ Private ☐ Home schooled ☐ Other (specify):
Grade: _____Teacher: _____

In special education? ☐ Yes ☐ No
If Yes, describe: _____

Does your child have an IEP? ☐ Yes ☐ No
In gifted program? ☐ Yes ☐ No

Has your child ever been held back in school? ☐ Yes ☐ No
If Yes, what year(s):_____

Which subjects does your child enjoy in school? _____

Which subjects does your child dislike in school?
_____

What grades does your child usually receive in school? _____

Have there been any recent changes in your child's grades? ☐ Yes ☐ No
If yes, describe: _____

Leisure/Recreational
Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	*How often?*

Eating Habits
Briefly describe your family's eating style and <u>who prepares each meal</u>:

Breakfast? Who prepares?
_____

Lunch? Who prepares?
_____

Dinner? Who prepares?
_____

Who is home after school when your child gets home?
_____

How many times a week do you eat dinner at the table together?
_____
How many times do you eat out per week?
_____
Who does the grocery shopping?
_____

Does your family eat vegetarian food only? __ YES __ NO

Are there other food restrictions your family follows?
_____
What are your family's schedules like every day, including work hours?
_____
_____
__
_____
__
_____
__
_____
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_____
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__