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Eating Disorder Questionnaire - Adult

Name: _____ Date: _____

Date of Birth: _____

Address: _____

Phone: _____ Cell: _____

Email: _____

Marital Status:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Single
<input type="checkbox"/>	Married
<input type="checkbox"/>	Separated
<input type="checkbox"/>	Divorced
<input type="checkbox"/>	Widowed

Current living arrangements:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	With parents and/or relatives
<input type="checkbox"/>	Dorm or with friends

<input type="checkbox"/>	With partner/spouse
<input type="checkbox"/>	Alone

Family Weight History:

Mother:

Is your mother currently living? Yes _____ No _____ Mother's age: _____

Describe mother's weight (check one):

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Severely Underweight
<input type="checkbox"/>	Underweight
<input type="checkbox"/>	Average Weight
<input type="checkbox"/>	Slightly Overweight
<input type="checkbox"/>	Overweight
<input type="checkbox"/>	Severely Overweight

Father:

Is your father currently living? Yes _____ No _____ Father's age: _____

Describe father's weight (check one):

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Severely Underweight
<input type="checkbox"/>	Underweight
<input type="checkbox"/>	Average Weight
<input type="checkbox"/>	Slightly Overweight
<input type="checkbox"/>	Overweight
<input type="checkbox"/>	Severely Overweight

Siblings:

Number of siblings and names:

How many siblings are overweight? _____ underweight? _____

Does anyone in your family have a history of dieting and/or pre-occupation with food/weight?

Yes _____ No _____ Please explain:

Body Image History:

Please indicate how satisfied you feel with the way your body is proportioned:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Very Dissatisfied
<input type="checkbox"/>	Dissatisfied
<input type="checkbox"/>	Slightly Satisfied
<input type="checkbox"/>	Satisfied
<input type="checkbox"/>	Very Satisfied

Please indicate how you feel about the different areas of your body:

	<input checked="" type="checkbox"/> Very Dissatisfied	<input checked="" type="checkbox"/> Dissatisfied	<input checked="" type="checkbox"/> Slightly Satisfied	<input checked="" type="checkbox"/> Satisfied	<input checked="" type="checkbox"/> Very Satisfied
Face					
Arms					
Shoulders					
Breasts					
Stomach					

Buttocks					
Thighs					
Legs					
Nose					
Eyes					
Ears					
Hair					

Please indicate how you see yourself when you look in the mirror:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Emancipated
<input type="checkbox"/>	Thin
<input type="checkbox"/>	Average
<input type="checkbox"/>	Slightly Overweight
<input type="checkbox"/>	Overweight
<input type="checkbox"/>	Extremely Overweight

Food History:

Please record a sample of your daily intake (food and liquid). Please indicate a “P” the times in which food/liquid was purged.

Breakfast: _____

Snack: _____

Lunch: _____

Dinner: _____

Snack: _____

How comfortable are you with your current food behaviors?

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Not at all Uncomfortable
<input type="checkbox"/>	Slightly Uncomfortable
<input type="checkbox"/>	Uncomfortable
<input type="checkbox"/>	Very Uncomfortable
<input type="checkbox"/>	Extremely Uncomfortable

How ready do you feel to let go of the thoughts/behaviors associated with the eating disorder?

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Not at all Ready
<input type="checkbox"/>	Somewhat Ready
<input type="checkbox"/>	Ready
<input type="checkbox"/>	Very Ready

Please elaborate on reasons why you checked the above box:

How willing would you be to gain 5-10 pounds if you knew the behaviors/thoughts would diminish?

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Not at all Willing
<input type="checkbox"/>	Somewhat Willing
<input type="checkbox"/>	Willing
<input type="checkbox"/>	Very Willing

Please list the behaviors/thoughts that you would want to change:

At what age did you first become concerned with your weight? _____

At what age did you begin restricting your intake? _____

At what age did you begin purging? _____

At what age did you begin bingeing? _____

Please check all symptoms you have felt since the development of your eating problems:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Feeling tired/weak
<input type="checkbox"/>	Feeling bloated
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Stomach pains
<input type="checkbox"/>	Feeling cold
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	Sore joints
<input type="checkbox"/>	Water retention
<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	Muscle spasms/cramps
<input type="checkbox"/>	Depression/irritability
<input type="checkbox"/>	Over sensitivity to noise/touch/light

Other (explain):

If you have a history of bingeing, please answer the following. Please check the times you are most likely to binge:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	8 -12 a.m.
<input type="checkbox"/>	12 - 6 p.m.
<input type="checkbox"/>	6 p.m. - midnight
<input type="checkbox"/>	midnight - 8 a.m.

Please check the places you are most apt to binge:

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Car
<input type="checkbox"/>	Home
<input type="checkbox"/>	Work/school
<input type="checkbox"/>	Restaurant

Other (explain):

Feelings History:

Please place a check next to the feelings that you have difficulty sitting with and/or expressing (that may then get expressed/released through your eating disorder):

<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Boredom
<input type="checkbox"/>	Disappointment
<input type="checkbox"/>	Confusion
<input type="checkbox"/>	Anger
<input type="checkbox"/>	Frustration

	Sadness
	Fear
	Guilt
	Hurt
	Jealousy
	Self-Loathing

Exercise History:

How many minutes per day do you currently exercise? _____

How many days per week do you currently exercise? _____

Are you, or have you ever, been involved in serious training for any sport ? Yes _____ No _____

If Yes, please list those sports:

Sexual History:

Have you ever engaged in sexual intercourse? Yes _____ No _____

Has anyone ever touched you in a way that felt uncomfortable, or forced you to participate in a sexual act against your will? Yes _____ No _____

Questions:

What are some questions you would like to have addressed in your next therapy session:

What are some questions that you would like to have addressed in the course of your history?
