Eating Disorder Worksheet

Section	Subsection	Instructions	Patient Response
Personal Information	Patient's Name	*Enter Full Name*	Jane Claire Smith
	Date of Birth	*Enter Date of Birth (DD/MM/YYYY)*	15/06/1991
	Gender	*Indicate your gender identity (Male, Female, Other, Prefer not to say)*	Female
	Contact Information	*Enter primary contact phone number and email address*	123-456-7890, janesmith@email.com
Medical History	General Health History	*Detail any past or current major health conditions or concerns. Do you have any allergies?*	Hypertension. No known allergies.
	Mental Health History	*Have you ever been diagnosed with a mental health condition? If yes, please provide details.*	Diagnosed with depression at age 24.
	Medications	*List all current medications and supplements, including dosages. Do you have any known drug allergies or intolerances?*	Prozac, 40mg daily. No known drug allergies.
Family History	General Health History	*Are there any major health conditions (diabetes, heart disease, etc.) in your immediate family members?*	Mother has Type 2 diabetes.
	Mental Health History	*Does anyone in your family have a history of mental health disorders (depression, anxiety, eating disorders, etc.)?*	Aunt was diagnosed with bulimia.

Lifestyle	Physical Activity	*How would you describe your level of physical activity (Sedentary, Light, Moderate, Active, Very Active)?*	Sedentary
	Occupation	*Are you currently employed or studying? If yes, please provide details.*	Employed as a software developer.
	Sleep Patterns	*How many hours of sleep do you typically get each night? Do you often have trouble sleeping?*	5-6 hours. Difficulty falling asleep.
Social History	Relationship Status	*What is your current relationship status (Single, In a Relationship, Married, Divorced, Widowed)?*	Single
	Support Network	*Who do you consider part of your social support network (Family, Friends, Community Groups, Others)?*	Friends and co-workers.
	Stress Factors	*Please list the top three major current stressors in your life.*	Work, financial stress, lack of sleep.
Weight History	Weight 1 Year Ago	*What was your weight 1 year ago?*	145 lbs
	Weight 6 Months Ago	*What was your weight 6 months ago?*	150 lbs
	Current Weight	*What is your current weight?*	130 lbs
	Weight Changes	*Have there been any significant fluctuations in your weight recently? Please describe.*	Lost 20 lbs over the past 6 months.
Food Intake	Meal Schedule	*How many meals do you have per day? At what times do you typically eat?*	2 meals per day, lunch around 1 pm, dinner around 8 pm.

	Eating Habits	*Describe your typical eating habits (e.g., types of food, portion sizes, speed of eating). Do you skip meals?*	Often skip breakfast. Small portions. Eats quickly.
	Dietary Restrictions	*Do you have any dietary restrictions (allergies, intolerances, personal or religious beliefs)?*	None
Eating Disorder Symptoms	Binging	*Have you ever experienced episodes of binge eating? If yes, please describe the frequency and context.*	Occasional binges when feeling stressed.
	Purging	*Have you ever engaged in purging behaviors (e.g., self-induced vomiting, laxative use)? If yes, please describe the frequency and context.*	No purging behaviors.
	Body Image	*How do you feel about your body? Have your feelings about your body changed recently?*	Unhappy, feels overweight despite weight loss.
	Exercise Habits	*What are your exercise habits? Have you noticed any changes recently?*	Rarely exercises. No recent changes.