

# Eating Disorder Worksheet

Patient's Name: \_\_\_\_\_ Date of Birth (DD/MM/YYYY): \_\_\_\_\_ dd / mm / yyyy

Gender

Male  Female  Other  Prefer not to say

Contact Information: \_\_\_\_\_

General Health History

Mental Health History

Medications

General Health History (Family)

Mental Health History (Family)

Physical Activity

- Sedentary  
 Light  
 Moderate  
 Active  
 Very Active

Occupation

Sleep Patterns

**Relationship Status**

- Single
- In a Relationship
- Married
- Divorced
- Widowed

**Support Network**

- Family
- Friends
- Community Groups
- Others

**Stress Factors**

Weight 1 Year Ago: \_\_\_\_\_ Weight 6 Months Ago: \_\_\_\_\_

Current Weight: \_\_\_\_\_

**Weight Changes**

**Meal Schedule**

**Eating Habits**

**Dietary Restrictions**

**Binging**

**Purging**

**Body Image**

