Comprehensive General Assessment: Eating Disorders

You may wish to keep this assessment as part of your patient file and/or sign off and use to forward to a secondary provider. Completion will likely require more than 1 visit.

SUMMARY

NAME _____ DATE _____

AGE _____ FAMILY DOCTOR _____

PRESENTING COMPLAINT

_____

_____

_____

SUMMARY OF HISTORY OF PRESENTING COMPLAINT

_____

_____

_____

GENERAL INFORMATION:

PERSONAL SITUATION: (INCLUDE MARITAL STATUS, STUDENT/EMPLOYED, LIVING ARRANGEMENTS)

_____

_____

_____

EATING DISORDER DIAGNOSIS AND COMORBID CONDITIONS:

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

☐ Reviewed with Patient ☐ Reviewed with Family

WEIGHT HISTORY

Height: _____ inches Current weight: _____ lbs.

How much would you like to weigh? _____ lbs.

How old were you when you became serious about trying to control your weight? _____ Years old

What is the heaviest weight you remember being at? _____ lbs. How old were you? _____

What is the lightest weight you remember being at? _____ lb. How old were you? _____

MENSTRUAL HISTORY

At what age did you first start menstruating?

_____ Years old **OR** ☐ I have never had a period

Do you have menstrual periods now?

- ☐ Yes, regularly every month
- ☐ Yes, but I skip a month once in a while
- ☐ Yes, but not very often (i.e. once in 3 months)
- ☐ No, I have not had a period in at least 3 months
- ☐ I am post-menopausal or have had a hysterectomy

How long has it been since your last period?

_____ weeks OR _____ months OR _____ years

Where was your weight when your periods became irregular/stopped? _____ lbs.

Have you previously been prescribed birth control? For what purpose?

_____

_____

_____

BODY IMAGE

When you look in the mirror do you feel you need to

☐ gain a little weight ☐ lose a little weight ☐ stay just where I am

Are there specific body parts that you are uncomfortable with?

_____

_____

_____

Have you undergone any procedures to alter your physical appearance including such things as bariatric surgery, plastic surgery or breast augmentation/reduction?

PROCEDURE	DATE OF PROCEDURE

NUTRITION

How many meals do you eat each day? _____ How many snacks do you eat each day? _____

Please describe a typical day of eating:

_____

_____

How many calories do you estimate you eat each day? _____

How many meals each week do you eat with your family?

☐ none ☐ 1-2 ☐ 3 - 5 ☐ 6-10 ☐ 11-15 ☐ 15+

Do you eat what the rest of your family is eating?

☐ yes, always ☐ most of the time ☐ once and a while ☐ never

Are you vegetarian? ☐ yes – Since when? _____ ☐ no

WEIGHT CONTROL

Have you ever restricted your food intake due to concern about your body size or weight?

☐ yes ☐ no

How old were you the very first time that you began to restrict your food intake due to concern about your body size?

_____ years old

How old were you when you became very serious about trying to control your weight?

_____ years old

How often do you exercise in a typical week? _____ times a week

How long do you exercise each time? _____ minutes

What kinds of exercise do you like to do? Why do you exercise?

_____

_____

Do you ever experience episodes of eating a very large amount of food (binge) in a relatively short period of time?

☐ yes ☐ no

How old were you when you first had a binge? _____ years old

How old were you when you began binge eating on a regular basis? _____ years old

During the last 3 months, how often have you typically had an eating binge?

☐ I have not binged in the last 3 months.
☐ Monthly, I usually binge _____ time(s) a month.
☐ Weekly, I usually binge _____ time(s) a week.
☐ Daily, I usually binge _____ time(s) a day.

What is the longest period you have had without bingeing since you began bingeing on a regular basis?

_____ days

How long does a binge usually last?

☐ Less than one hour ☐ 1 – 2 hours
☐ More than 2 hours ☐ All day or all evening

Many people find it embarrassing to talk about their binges but it would be helpful for me to understand a little bit about them. What do you typically eat during a binge?

_____

_____

Many people try to rid themselves of the food when the binge is over, have you ever tried to make yourself sick (vomit)?

☐ yes ☐ no

How old were you when you made yourself sick (vomited) for the first time? _____ years old

When things were at their worst, how often did you make yourself sick (vomit) each week?

a) _____ times per week

b) How long ago was that? _____ months

What is the longest period you have had without vomiting since you began vomiting on a regular basis?

_____ days

How often do you eat a "normal" meal without binge eating and/or without vomiting?

☐ Never ☐ Less than one meal a week
☐ About one meal a week ☐ Several meals a week
☐ One meal a day ☐ More than one meal a day

Have you ever used laxatives to control your weight or to "get rid of food"?

☐ yes ☐ no

How old were you when you first took laxatives to control your weight? _____ years old

How old were you when you began taking laxatives on a regular basis? _____ years old

During the last 3 months how often have you taken laxatives to help control your weight?

☐ I have not taken laxatives in the last 3 months.
☐ Monthly, I usually take laxatives _____ time(s) a month.
☐ Weekly, I usually take laxatives _____ time(s) a month.
☐ Daily, I usually take laxatives _____ time(s) a day.

How many laxatives do you usually take each time? _____ laxatives

Have you ever taken diet pills?

☐ yes – What kind? _____ ☐ no

During the last 3 months, how often have you typically taken diet pills?

☐ I have not taken diet pills in the last 3 months.
☐ Monthly, I usually take diet pills _____ time(s) a month.
☐ Weekly, I usually take diet pills _____ time(s) a week.
☐ Daily, I usually take diet pills _____ time(s) a day.

Have you ever taken diuretics (water pills)?

☐ yes ☐ no

During the last 3 months, how often have you typically taken diuretics?

☐ I have not taken diuretics in the last 3 months.
☐ Monthly, I usually take diuretics _____ time(s) a month.
☐ Weekly, I usually take diuretics _____ time(s) a week.
☐ Daily, I usually take diuretics _____ time(s) a day.

TREATMENT HISTORY

Have you ever received treatment for an eating disorder?

☐ no ☐ yes – please indicate type and when (Check all that apply)

☐ inpatient when I was _____ years old for _____ months
☐ day hospital when I was _____ years old for _____ months
☐ outpatient when I was _____ years old for _____ months
☐ individual therapy when I was _____ years old for _____ months
☐ group when I was _____ years old for _____ months
☐ family when I was _____ years old for _____ months
☐ other _____ when I was _____ years old for _____ months

Have you ever attended treatment for issues other than your eating disorder?

☐ no ☐ yes – please indicate type and when (Check all that apply)

- ☐ inpatient when I was _____ years old for _____ months
- ☐ day hospital when I was _____ years old for _____ months
- ☐ outpatient when I was _____ years old for _____ months
- ☐ individual therapy when I was _____ years old for _____ months
- ☐ group when I was _____ years old for _____ months
- ☐ family when I was _____ years old for _____ months
- ☐ other _____ when I was _____ years old for _____ months

These treatments were for help with:

_____

_____

_____

Have you been admitted to the hospital in the past 2 months? ☐ **Yes** ☐ **No**

If yes, how many times were you in the hospital? _____ times

If yes, how many days in total were you in the hospital? _____ days

Have you ever been hospitalized for eating problems?

☐ no ☐ yes how many times _____

CURRENT AND PAST BEHAVIOURS

Alcohol Use

_____

_____

Drug Use

_____

_____

Self-Harm

_____

_____

ABUSE HISTORY

Have you been physically, emotionally or sexually abused in the past? Are you currently in an abusive relationship?

_____

_____

_____

FAMILY HISTORY AND RELATIONSHIPS

(Note: substitute any significant family member/guardian/caregiver who has raised or is raising the individual)

Which category best describes/or described your mother's weight?

☐ Underweight ☐ Normal weight ☐ Above average weight ☐ Very overweight

How preoccupied with food or weight is/was your mother?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very much ☐ Extremely

Which category best describes/or described your other guardian/father's weight?

☐ Underweight ☐ Normal weight ☐ Above average weight ☐ Very overweight

How preoccupied with food or weight is/was your other guardian/father?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very much ☐ Extremely

How many siblings do you have? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How many siblings are underweight? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How many siblings are normal weight? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How many siblings are above average weight?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ other _____

How would you describe the quality of your relationship with your mother? Or other significant caregiver?

_____

_____

How would you describe the quality of your relationship with your father? Or other significant caregiver?

_____

_____

How would you describe the quality of your relationship with your siblings?

_____

_____

How would you describe the quality of your relationship with your spouse/partner/boyfriend/girlfriend?

_____

_____

How would you describe the quality of your relationship with your children?

_____

_____

SOCIAL SUPPORTS/RELATIONSHIPS

How many close friends do you have?

☐ no one ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5

How many people (including family) could you talk to about an important personal problem?

☐ no one ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5

How many hours a week do you socialize with friends outside of work/school hours? (e.g. dinner, talk on phone, etc.)

☐ less than one hour ☐ 1-2 hours ☐ 3 - 4 hours ☐ 5-6 hours
☐ 7-8 hours ☐ 9-10 hours ☐ more than 10 hours

How many hours a week do you engage in family activities?

☐ less than one hour ☐ 1-2 hours ☐ 3 - 4 hours ☐ 5-6 hours
☐ 7-8 hours ☐ 9-10 hours ☐ more than 10 hours

With whom have you discussed your current concerns?

_____

_____

Are they concerned for your health?

_____

_____

How motivated are you to do something about your current health issues?
(on a scale of 0-10, where 0=not at all, 10= do whatever I have to)

_____

_____

_____ _____
Completing Physician Date

Adapted from Johnson (1985) and Northern Health (2006)

Comprehensive Medical Assessment: Eating Disorders

You may wish to keep this assessment as part of your patient file and/or sign off and use to forward to a secondary provider.

LAST PHYSICAL ASSESSMENT _____

APPEARANCE DURING ASSESSMENT _____

_____

CURRENT REVIEW OF SYSTEMS

- ☐ Cardiovascular
- ☐ Gastrointestinal
- ☐ Endocrine
- ☐ Gynaecologic
- ☐ Dermatologic
- ☐ musculoskeletal

DIAGNOSIS:

_____

_____

_____

PHYSICAL COMPLICATIONS: Summary

_____

_____

_____

LABORATORY INVESTIGATIONS: Summary

_____

_____

_____

Routine Completed:

- ☐ CBC
- ☐ BUN
- ☐ Creatinine
- ☐ Fasting Insulin
- ☐ Electrolytes
- ☐ FBG
- ☐ Liver Function
- ☐ Hormone Panel

Further Recommended:

- ☐ EKG (chest pain, palpitations)
- ☐ Liver function (Weight loss, alcohol abuse)
- ☐ CPK (abusing Ipecac)
- ☐ Amylase (gastrointestinal symptom)
- ☐ Calcium, phosphorous (chronic amenorrhea or fractures) magnesium
- ☐ Endoscope or x-ray exams

OTHER:

Insight into illness/eating disorder (0-10, 10= high) _____

Motivation to work towards recovery (0-10, 10= high) _____

MEDICATIONS:

ALLERGIES:

SLEEP PATTERN

CARDIOVASCULAR FUNCTIONING (dizziness, blackouts, postural hypotension, chest pain, palpitations and edema)

GASTROINTESTINAL FUNCTIONING (Vomiting with ___, without____blood, constipation, diarrhea, bloating, abdominal pain, nausea)

DENTAL HISTORY (Issues reported, recent dental exam)

HAIR AND SKIN (hair loss, dullness, thinness, dryness, fingernails, lanugo)

GYNOCOLOGICAL HISTORY (secondary sexual characteristics, onset menarche, birth control, periods, sexual history, pregnancies, fertility, PCOS)

MUSCOLOSKELETAL (weakness, cramps, pain, fractures)

NEUROLOGICAL FUNCTIONNING (headaches, seizures, night vision, visual disturbances, `black outs')

Physical Examination

Height _____

Weight _____ * undressed- preferably facing away from the scale (See 'Weighing your Patients' sheet

Blood Pressure:

Sitting _____ Standing _____ Pulse _____

Vision: _____

Parotid: _____

Thyroid: _____

Dentition and Hydration: _____

Skin: (lanugo, stria, fingernails, palm excoriation/Russell's sign) _____

_____

Extremities: (cyanosis, temperature) _____

CNS: (reflexes, strength) _____

_____

Heart: (chest pains, palpitations) _____

_____

Chest: _____

_____

Mental Status: (as appropriate) _____

Measurements: _____

BMI- (see 'BMI' instruction sheet) _____

_____ _____

Completing Physician Date

Adapted from Johnson (1985) and Northern Health (2006)