Eating, Weight, and Body Image History

Complete this only if Dr. Ireland has asked you to. It is not part of the standard intake.

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Dr. Ireland sends this form when eating, weight, or body image is part of what you are working on together. Answer what applies to you and leave the rest blank. Some of these questions are asked very directly because the behaviors they describe carry medical risk, and she needs an accurate picture to keep you safe. Nothing here replaces conversation with her.

NAME | DATE OF BIRTH | TODAY'S DATE

BACKGROUND

AGE OF YOUR FIRST DIET OR ATTEMPT TO CHANGE YOUR WEIGHT | APPROXIMATE NUMBER OF DIETS SINCE

Has a provider ever given you an eating disorder diagnosis? ☐ Yes ☐ No

IF YES, WHAT DIAGNOSIS AND WHEN

Do any family members have a history of eating disorders? ☐ Yes ☐ No

IF YES, WHO AND WHAT IS KNOWN

Do you have diabetes? ☐ Yes ☐ No

IF YES, TYPE, DATE OF DIAGNOSIS, AND HOW IT IS MANAGED

EATING PATTERNS

TYPICAL NUMBER OF MEALS PER DAY | TYPICAL NUMBER OF SNACKS PER DAY | LONGEST YOU TYPICALLY GO WITHOUT EATING

Please indicate how often each of the following has applied to you over the past three months.

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Skipping meals	☐	☐	☐	☐	☐	☐
Limiting how much food you eat	☐	☐	☐	☐	☐	☐
Limiting which foods you allow yourself to eat	☐	☐	☐	☐	☐	☐
Going a full day or longer without eating (fasting)	☐	☐	☐	☐	☐	☐
Counting calories, grams, or points	☐	☐	☐	☐	☐	☐
Following rigid food rules or rituals	☐	☐	☐	☐	☐	☐
Eating in secret or hiding food	☐	☐	☐	☐	☐	☐
Eating an unusually large amount of food in one sitting	☐	☐	☐	☐	☐	☐
Feeling out of control over your eating	☐	☐	☐	☐	☐	☐
Eating past fullness to the point of discomfort	☐	☐	☐	☐	☐	☐
Feeling intense guilt or shame after eating	☐	☐	☐	☐	☐	☐

COMPENSATORY BEHAVIORS

These are asked directly because they carry medical risk. Honest answers help Dr. Ireland keep you safe, and nothing here is a subject for judgment.

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Self-induced vomiting	☐	☐	☐	☐	☐	☐

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Laxative use to control weight or shape	☐	☐	☐	☐	☐	☐
Diuretic or water pill use	☐	☐	☐	☐	☐	☐
Diet pills, appetite suppressants, or stimulants	☐	☐	☐	☐	☐	☐
Skipping or reducing insulin to control weight	☐	☐	☐	☐	☐	☐
Exercising to compensate for eating	☐	☐	☐	☐	☐	☐
Exercising when injured, ill, or exhausted	☐	☐	☐	☐	☐	☐
Chewing and spitting out food	☐	☐	☐	☐	☐	☐
Fasting after eating	☐	☐	☐	☐	☐	☐

TYPICAL EXERCISE TYPE AND DURATION PER DAY

DAYS PER WEEK

Do you feel anxious, guilty, or agitated if you cannot exercise? ☐ Yes ☐ No

BODY IMAGE AND PREOCCUPATION

	NEVER	PAST ONLY	<1X/WK	1-2X/WK	3-6X/WK	DAILY+
Weighing yourself	☐	☐	☐	☐	☐	☐
Checking your body in mirrors, photos, or by measuring	☐	☐	☐	☐	☐	☐
Avoiding mirrors, photos, or certain clothing	☐	☐	☐	☐	☐	☐
Thoughts about food, weight, or shape interfering with your day	☐	☐	☐	☐	☐	☐
Avoiding eating in front of other people	☐	☐	☐	☐	☐	☐

HOW DO THOUGHTS ABOUT FOOD, WEIGHT, OR BODY SHAPE AFFECT YOUR DAILY LIFE, WORK, OR RELATIONSHIPS?

PHYSICAL SYMPTOMS

CHECK ANY YOU EXPERIENCE

- ☐ Dizziness or lightheadedness
- ☐ Chest pain
- ☐ Hair thinning or loss
- ☐ Acid reflux or heartburn
- ☐ Swelling in hands, feet, or face
- ☐ Difficulty sleeping
- ☐ Fainting
- ☐ Feeling cold much of the time
- ☐ Dry skin or brittle nails
- ☐ Bloating or stomach pain
- ☐ Irregular or absent menstrual periods
- ☐ None of these
- ☐ Heart palpitations
- ☐ Fatigue or weakness
- ☐ Constipation
- ☐ Dental problems or enamel erosion
- ☐ Difficulty concentrating

DATE OF LAST MENSTRUAL PERIOD, IF APPLICABLE

DATE OF LAST BLOOD WORK OR LABS

DATE OF LAST EKG, IF EVER

Have you ever had a bone density scan? ☐ Yes ☐ No

IF YES, WHEN AND WHAT WERE THE RESULTS

Are you currently under the care of a physician for any of the above? ☐ Yes ☐ No

IF YES, WHO AND FOR WHAT

PRIOR TREATMENT

PROGRAM OR PROVIDER	LEVEL OF CARE	DATES	OUTCOME

Levels of care include outpatient therapy, nutrition counseling, intensive outpatient (IOP), partial hospitalization (PHP), residential, and inpatient or medical stabilization.

Are you currently working with a registered dietitian? ☐ Yes ☐ No

IF YES, NAME AND HOW OFTEN YOU MEET

WHAT HAS BEEN MOST HELPFUL IN PAST TREATMENT? WHAT HAS NOT BEEN HELPFUL?

ANYTHING ELSE

IS THERE ANYTHING ABOUT YOUR RELATIONSHIP WITH FOOD, YOUR BODY, OR YOUR WEIGHT THAT THIS FORM DID NOT ASK ABOUT AND YOU WOULD LIKE DR. I

Thank you. This gives Dr. Ireland a clear starting point without spending a session gathering it.

CLIENT SIGNATURE DATE