lauramangum rd,ld
eat right. be fit. live well.

EATING DISORDER NUTRITION HISTORY FORM

Name: _____ Age: _____ Height: _____

Reason for appointment: _____

_____

Weight:

Highest weight: _____ When: _____

Lowest weight: _____ When: _____

Current weight: _____ When: _____

Family History: (please circle)

Mother's weight: over under normal ED/Diet/Food issues? Yes No

Father's weight: over under normal ED/Diet/Food issues? Yes No

Sister's weight: over under normal ED/Diet/Food issues? Yes No

Brother's weight: over under normal ED/Diet/Food issues? Yes No

Brief History of your weight:

_____

_____

_____

_____

_____

Do you currently see yourself as: Thin Fat Normal

What do you think is a normal non-eating disorder weight for you? _____

When you did not have an eating disorder, what did you weigh? _____

MENSES:

If applicable, at what age did you first begin menses? _____

What did you weigh at that time? _____

What did you weigh two years after starting menses? _____

Do you currently have regular periods? Yes No

If not, when was your last period? _____

If so, do you take birth control hormones? Yes No

DIET:

Are there foods that you do not eat or that you try to avoid? Yes No

What are they? _____

_____

_____

Notes:
(Dietian use only)

Weight: _____

BMI: _____

%IBW: _____

If applicable, what are the groups of food that you only allow yourself to eat when you binge or are planning to purge?

_____

_____

Write down what you ate yesterday:

_____

_____

Was this typical for you? Yes No

If not, what was different?

_____

_____

Write down what you eat on a bad day:

_____

_____

Write down what you eat on a good day:

_____

_____

Do you think that your diet is well balanced? Yes No

What do you want to be different about your food intake?

_____

_____

Who prepares your food? _____

Who grocery shops for you? _____

How often do you eat in restaurants? _____

What kind of restaurants? _____

Do you eat dinner with your family? _____

BEHAVIORS

Do you have any food behaviors or rituals? Yes No

If so, what are they?

_____

_____

Notes:
(Dietian use only)

How honest are you able to be about your food behaviors?

_____

_____

Circle any of the following that you have ever done:

Fasting	Compulsive Eating	Inducing Vomiting
Dieting	Emotional Eating	Involuntary Vomiting
Using laxatives	Compulsive Exercise	Diuretic Use
Using diet pills	Binge Eating	

Circle any of the following that you are still doing:

Fasting	Compulsive Eating	Inducing Vomiting
Dieting	Emotional Eating	Involuntary Vomiting
Using laxatives	Compulsive Eating	Diuretic Use
Using diet pills	Compulsive Exercise	

How often are you doing the behaviors above? _____

MEDICATIONS, MEDICAL CONCERNS, and SUPPLEMENTS

What medications are you taking?

_____

_____

What vitamins and supplements are you taking?

_____

_____

Do you have any food allergies or intolerances? Yes No

If so, what are they? _____

HUNGER and FULLNESS SYMPTOMS

Do you recognize hunger? Yes No

What does hunger feel like to you?

_____

Do you recognize fullness? Yes No

What does fullness feel like to you?

_____

TREATMENT HISTORY

Have you ever seen a dietitian? Yes No

Explain:

_____

_____

What did you like or dislike?

_____

_____

Notes:
(Dietian use only)

Have you ever been to a treatment program? Yes No

If yes, which one? _____ When? _____

What did you like or dislike about the last treatment program you were in?

_____

_____

Sleep quality on scale from 1-10 (10 being great)? _____ Avg. amount of sleep nightly? _____

EXERCISE

If applicable, what type of exercise do you do? _____

How much and how often? _____

How often do you eat the following food/beverages?
Please check as appropriate.

	Daily	Several times/week	Seldom	Never
Fruits:				
I eat fresh fruit…	____	____	____	____
I eat canned fruit…	____	____	____	____
I eat dried fruit…	____	____	____	____
I drink juice…	____	____	____	____
Vegetables:				
I eat fresh veggies…	____	____	____	____
I eat frozen veggies…	____	____	____	____
I eat canned veggies…	____	____	____	____
Grains:				
I eat whole grains…	____	____	____	____
I eat white flour products…	____	____	____	____
I eat beans/green peas…	____	____	____	____
I eat corn…	____	____	____	____
I eat potatoes/sweet potato	____	____	____	____
Milk:				
I drink milk…	____	____	____	____
What kind of milk? _____				
I eat yogurt…	____	____	____	____
Cheese:				
I eat regular white cheese…	____	____	____	____
I eat regular yellow cheese…	____	____	____	____
I eat lowfat/fat free cheese…	____	____	____	____
Soy:				
I eat soy products…	____	____	____	____
If so, which type? _____				
Meat:				
I eat beef…	____	____	____	____
I eat pork…	____	____	____	____
I eat chicken…	____	____	____	____
I eat fish…	____	____	____	____
I eat eggs…	____	____	____	____
Fats:				
I eat butter/margarine…	____	____	____	____
I use oils…	____	____	____	____
I use salad dressing…	____	____	____	____
I eat nuts…	____	____	____	____
I eat peanut butter…	____	____	____	____

Notes:
(Dietian use only)

	Daily	Several times/week	Seldom	Never
Sweets:				
I eat sweets…	____	____	____	____
Sodas:				
I drink regular sodas…	____	____	____	____
I drink diet sodas…	____	____	____	____
Alcohol:				
I drink regular alcohol…	____	____	____	____

If so what type?_____

Coffee:

I drink regular coffee… ____ ____ ____ ____

# of cups?_____

What do you add to your coffee? _____

Water:

Do you consider your water intake good, fair, or poor? _____

Artificial Sweetners

I use artificial sweetners…	____	____	____	____

What type(s)? _____

Notes:
(Dietian use only)