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? ______________________________

____

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?

____

____

How many cups a day do you drink of the following beverages?

Coffee	______	Juice	______
Soda	______	Milk	______
Tea	______	Other	______

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?

____

____

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?

____

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?

____

____

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…	____	____	____	____

	Daily	Several times/week	Seldom	Never
Fats:				
I eat butter/margarine…	____	____	____	____
I use oils…	____	____	____	____
I use salad dressing…	____	____	____	____
I eat nuts…	____	____	____	____
I eat peanut or nut butter…	____	____	____	____
I eat avocados…	____	____	____	____
I eat olives…	____	____	____	____
I eat hummus…	____	____	____	____
Sweets:				
I eat sweets…	____	____	____	____
Sodas:				
I drink regular sodas…	____	____	____	____
I drink diet sodas…	____	____	____	____
Alcohol:				
I drink alcohol…	____	____	____	____
If so, what type? ____________________________				
Coffee:				
I drink coffee…	____	____	____	____
(# of cups:)				
What do you drink in your coffee? ____				
Other:				
I drink other beverages:	____	____	____	____
If so, what type? ____________________________				
Water:				
Do you consider your water intake good, fair, or poor? ____________________________________				