Eating Disorder Assessment Intake Form

Personal Information

Name

Date of Birth

Gender

Contact Number

Email

Reason for Assessment

Please describe your concerns

Medical History

Have you been previously diagnosed with an eating disorder?

If yes, please provide details

Are you currently taking any medications?

Do you have any significant medical conditions?

Eating Patterns

How many meals do you eat per day?

Do you ever feel out of control while eating?

Do you engage in behaviors to prevent weight gain (e.g., vomiting, laxatives, over-exercising)?

If yes, please specify behaviors and frequency

Body Image and Weight Concerns

How do you feel about your body and weight?

Are you currently trying to change your weight or shape?

Additional Information

Do you have a support system?

What do you hope to achieve from this assessment?