Sage Healing Counseling Services, PLLC

Eating Disorders Screening Tool

This short screening is appropriate for ages 13 and up. It is not intended for diagnostic purposes. It is intended to be completed and given to your counselor at the time of your scheduled appointment.

1. How much more or less do you feel you worry about your weight and body shape than other people your age?

- ◯ I worry a lot less than other people
- ◯ I worry a little less than other people
- ◯ I worry about the same as other people
- ◯ I worry a little more than other people
- ◯ I worry a lot more than other people

2. How afraid are you of gaining 3 pounds?

- ◯ Not afraid at all
- ◯ Slightly afraid
- ◯ Moderately afraid
- ◯ Very Afraid
- ◯ Terrified

3. When was the last time you went on a diet?

- ◯ I have never been on a diet
- ◯ One year ago
- ◯ 6 months ago
- ◯ 3 months ago
- ◯ Less than 1 month ago
- ◯ I'm on a diet now

4. Compared to other things in your life, how important is your weight to you?

- ◯ My weight is not important compared to other things in my life
- ◯ My weight is a little more important than other things in my life
- ◯ My weight is more important than most, but not all, things in my life
- ◯ My weight is the most important thing in my life

5. Do you ever feel fat?

- Never
- Rarely
- Sometimes
- Often
- Always

6. In the past 3 months, how many times have you had a sense of loos and control AND you also ate what most people would regard as an unusually large amount of food at one time, defined as definitely more than most people would eat under similar circumstances? (Enter a number)

7. In the past three months, how many times have you done any of the following as a means to control your weight and shape (enter a number):

- Made yourself throw up?
- Used diuretics or laxatives?
- Exercised excessively?
- Fasted intentionally in an attempt to prevent weight gain?

8. Do you consume a small amount of food (i.e. less than 1200 calories/day) on a regular basis to influence your shape or weight?

- Yes
- No

9. Are you currently in a treatment for an eating disorder?

- Yes
- No

Not currently, but I have been in the past

10. What is your height?

11. What was your lowest weight in the past year, including today in pounds?

12. What is your current weight in pounds?

13. Do you struggle with a lack of interest in eating or food AND has this led to major problems for you (e.g. weight loss/nutritional problems; major impairment in functioning)?

- ◯ Yes
- ◯ No

14. Do you avoid many foods because of such features as texture, consistency, temperature, or smell AND has this led to major problems for you (e.g. weight loss/nutritional problems, major impairment in functioning)?

- ◯ Yes
- ◯ No

15. Do you avoid certain or many foods, not for a medical reason such as gluten sensitivity, but because of fear of experiencing negative consequences like choking or vomiting AND has this led to major problems for you (e.g. significant weight loss/nutritional problems; major impairment in functioning)?

- ◯ Yes
- ◯ No

16. Have you experienced significant weight loss (or are at a low weight for your age and height) but are not overly concerned with the size and shape of your body?

- ◯ Yes
- ◯ No