

## Eating Disorder Questionnaire

1. Have you had a strong desire to lose weight? Yes  No
2. Does your weight affect how you feel about yourself as a person? Yes  No
3. Have you limited your food intake to lose weight? Yes  No
4. Do you often compare your body size to others'? Yes  No
5. Do you feel you are overweight despite being average for your height? Yes  No
6. Have you tried following specific diet rules i.e. limiting your caloric intake in order to lose weight? Yes  No
7. Has your preoccupation with food made it difficult to concentrate on things you are interested in? Yes  No
8. Does your family show concern about your weight? Yes  No
9. Do you think everyone's problems are more important than your own? Yes  No
10. Do you often feel your life is empty? Yes  No
11. Do you feel you need frequent approval from others? Yes  No
12. Do you think people judge you negatively? Yes  No
13. Do you feel your life would be better if you weighed less? Yes  No
14. Have you had a definite fear that you might gain weight? Yes  No
15. Do you judge people based only on their weight? Yes  No
16. Do you constantly say negative things to yourself, i.e. that you do not deserve to be happy? Yes  No
17. Do you allow food to dominate your life? Yes  No

18. Do you feel you do not deserve to eat? Yes  No
19. Do you frequently question your judgments? Yes  No
20. Do you think you have a negative self evaluation? Yes  No
21. Do you believe that you may suffer from Anorexia, Bulimia or Compulsive Overeating? Yes  No
22. Do you feel your family burdens you with their problems? Yes  No
23. Do you eat so much that you feel uncomfortably full? Yes  No
24. Are you perfectionist or overachieving? Yes  No
25. Do you feel your problems are a burden to others? Yes  No
26. Do you fear losing control over your food intake? Yes  No
27. Have you recently lost a significant amount of weight in a short period of time? Yes  No
28. Do you believe yourself to be fat despite people saying you are not fat? Yes  No
29. Have you gone an entire day without eating in order to lose weight? Yes  No
30. How frequently do you eat an amount that is considered an unusually large amount of food? Yes  No
31. Do you frequently feel a loss of control over your eating? Yes  No
32. Do you vomit as a means of controlling your weight? Yes  No
33. Do you exercise excessively as a means of controlling your weight? Yes  No
34. Do you take laxatives as a means of controlling your weight? Yes  No
35. Do you eat in secret? Yes  No

36. Do you worry about not having enough food? Yes  No

37. Do you feel guilty for eating? Yes  No

38. has your weight and shape influenced how you judge yourself as a person? Yes  No

39. How often do you weigh yourself? Yes  No

40. Do you feel uncomfortable seeing your shape? Yes  No

41. Do you feel uncomfortable about others seeing your shape? Yes  No

OCHPA Patient Form