

Parent Questionnaire

**Eating Disorder Questionnaire for New Patients/Families**

Before we can see your child for an eating disorder consultation, we need you to answer the following questions about your child and family.

**Child's Name** \_\_\_\_\_ **Birth date** \_\_\_\_\_

**Name of School** \_\_\_\_\_ **Grade** \_\_\_\_\_

Do you know your child's current weight \_\_\_\_\_ Height \_\_\_\_\_

What was your child's highest weight? \_\_\_\_\_ How long ago? \_\_\_\_\_

What was your child's lowest weight? \_\_\_\_\_ How long ago? \_\_\_\_\_

When did you become concerned about your child's weight? \_\_\_\_\_

\_\_\_\_\_

What changes have you noticed in your child's eating habits? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your child a vegetarian? \_\_\_\_\_ If yes, what won't he/she eat? \_\_\_\_\_

\_\_\_\_\_

Is there a family history of eating disorders? \_\_\_\_\_ If yes, who and what problem?

\_\_\_\_\_

\_\_\_\_\_

Is there a family history of depression, anxiety, substance abuse or other psychiatric illness?

\_\_\_\_\_

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\_\_\_\_\_

Has your child been diagnosed with depression, anxiety, obsessive compulsive disorder or other

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iatric illness? \_\_\_\_\_ If yes, what type of treatment did they receive? \_\_\_\_\_

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Has your child ever been physically or sexually abused? \_\_\_\_\_ If yes, when and how?

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Is your child currently working with a counselor? \_\_\_\_\_ If yes, who and through which office or program? \_\_\_\_\_

Is your child currently working with a dietician? \_\_\_\_\_ If yes, who and through which hospital? \_\_\_\_\_

Has your child ever been admitted to the hospital or a residential treatment facility for their eating disorder? \_\_\_\_\_ If yes, where, when and for how long? \_\_\_\_\_

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Is your child currently taking any medications? \_\_\_\_\_ If yes, please list.

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Is there a family history of obesity, diabetes or heart disease? \_\_\_\_\_ If yes, in whom and when was it diagnosed? \_\_\_\_\_

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What extra-curricular activities does your child participate in? \_\_\_\_\_

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How does your child exercise? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you concerned that your child is vomiting after they eat? \_\_\_\_\_ If yes, why?

\_\_\_\_\_

Has your child ever been admitted to the hospital or had previous surgeries? \_\_\_\_

If yes, please list when and for what reason. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your family's living arrangements? \_\_\_\_\_

\_\_\_\_\_

Have there been any stressors in your home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your child experiencing any stressors at school or with peers? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How does your child do in school? Has there been any change in his/her level of academic performance? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child bring their lunch to school or do they eat hot lunch from the cafeteria?

\_\_\_\_\_

What are your family's attitudes regarding weight? Has anyone in your family struggled with their weight? \_\_\_\_\_

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Parent Questionnaire

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How do the adult members of your family maintain a healthy weight?

Is there pressure to diet in your family? Are any family members currently on a diet?

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## Parent Questionnaire

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Please describe a typical day, in detail, of what and how your child eats and drinks.

	<u>Quantity and type of food</u>	<u>Behaviors during the meal</u> <u>And where they eat it</u>
<b>Breakfast</b>	<hr/> <hr/> <hr/> <hr/>	
<b>Snack</b>	<hr/> <hr/>	
<b>Lunch</b>	<hr/> <hr/> <hr/> <hr/>	
<b>Snack</b>	<hr/> <hr/>	
<b>Dinner</b>	<hr/> <hr/> <hr/> <hr/>	
<b>Snack</b>	<hr/> <hr/>	

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