

Eating Disorders Questions

1. Are you comfortable with your weight and shape? Yes No
2. Are you doing anything to change your shape or weight? Yes No
3. How much would you like to weigh? _____
4. Have you been narrowing your food choices, or avoiding certain food groups, e.g., fat? Yes No
5. Has there been increased absences from family meals (already eaten – eat later)? Yes No
6. Switch to vegetarianism? Yes No
7. Bathroom visits (often with running water) after meals? Yes No
8. Excessive exercise that is solitary, done at unusual hours or for extreme duration, pursued with obsessive determination (often anger or panic if missed)?
Yes No
9. Gradual withdrawal from social activities? Yes No
10. Weight loss in adolescent? Yes No
11. Food disappearing? Yes No

SCOFF

- S** - Do you make yourself sick because you feel uncomfortably full? Yes No
- C** - Do you worry you have lost control over how much you eat? Yes No
- O** - Have you recently lost 10 pounds in a 3-month period? Yes No
- F** - Do you believe you are fat when others say you are thin? Yes No
- F** - Would you say food or thoughts of food dominate your life? Yes No