CEED | THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Eating Disorder Interview

Name:	**Date:**	
D.O.B	Age:	Pronouns:
Address:		Ph.
Reason for referral for assessment:		

Client's account of presenting problem:
History of problem, onset, treatment to date

Interests and work:

Interests/ hobbies
Education and employment

Relationships:

Peer/Social Relationships & Family

Mood and Coping

Depression, Anxiety, Coping

Identity and Body Image

General Self-worth

How do you feel about yourself overall? Personal strengths /weaknesses of self-worth & self-esteem:

Thoughts/Feelings & Beliefs around Weight & Shape

How do you feel about your body at the moment? What words would you use to describe your body shape/ weight? Do you have an ideal weight/size? Does your body match this? How do you feel about gaining weight? How do you feel about losing weight?

Does your weight and/or body shape have an impact on how you feel about yourself?

Do you think about this a lot? What impact does this have on you day-to-day?

Body Checking

Have you noticed yourself checking your body for change? (i.e. mirror, touching, clothes, comparing to other in real life or social media, accounts on Instagram, weighing, measuring, pinching etc).

Eating and weight control behaviours

Eating & Weight Control Behaviours:

Have you ever been so worried about your shape/ weight that you've done something to try to change it?

Are you currently doing anything to manage your weight or eating?

Do you know if you weight has changed recently? Have you intentionally or unintentionally lost/ gained weight?

Restriction:

Are you following a 'diet?' Have you been deliberately trying to limit the amount of food you eat or avoid particular foods to influence your weight?
Do you skip meals or go for a long time without eating? Could you give me an example of when this last happened? How often do you do this? When did this start?
Follow up questions for restriction: How long have you been conscious of how much you were eating and trying to reduce that? Why do you restrict? Why is it important for you to lose weight?

Could you give me an example of your typical day in terms of your eating? What would say is your ideal (preferred) way of eating e.g. 'good' vs 'bad' day?

Breakfast:	Lunch:	Dinner:	Notes:

Morning Tea:	Afternoon Tea:	Snacks/Drink:

Binging (subjective or objective):

Do you ever eat more than you are comfortable with? Are you ever afraid to eat anything for fear that you won't be able to stop?

Follow up questions for bingeing: Can you tell me what you would have in a typical binge? (Use a large example so if the person does binge in large quantities they do not feel as ashamed). Is there any triggers that you are aware of that contribute to your bingeing? After you binge what do you do and how do you feel? When you are not bingeing what is your eating pattern like?

Vomiting:

Have you ever vomited as a way to control your weight/ shape? How often/ when do you vomit?

Laxatives, Diuretics / other substances used for weight control (e.g. caffeine or other stimulants):

Have you ever used laxatives, diuretics etc as a way to control your weight/ shape? Have you ever used steroids?

Exercise & physical activity

Is physical activity a part of your course? How much is required in a usual day/ week?
What physical activity/ exercise do you do outside of this? What is the main reason you exercise?
Compulsive exercise: Does how much you eat depend on how much exercise you do? Do you worry you'll gain weight if you don't exercise? Do you exercise when you are unwell? What happens if you don't exercise? Do you ever feel guilty if you don't exercise? Does exercise get in the way of other aspects of life?

Substance use:

Include any substance use, frequency, duration & context.

Relevant medical/psychiatric Hx

Current psychiatric conditions & previous medical / psychological / dietetic interventions:

Psychiatric risk:

Suicide risk:
Suicidal ideation, plan & intent

Self-harm:

Clients Motivation to engage in eating disorder treatment

What's your perspective around getting help for this issue? Do you see there is a problem?

Please indicate clinicians impression of the client's motivation to engage in eating disorder treatment:

	Pre contemplation	Contemplation	Preparation	Action	Maintentance	Relapse
Stage of Change	Not considering change	Acknowledges some problems with ED thinking and behaviours	Commitment to change and developing plan for change	Actively taking steps to address ED thinking and behaviours	Lower use of ED thinking and behaviours	Returned to previous ED pattern of behaviour & thinking

Other health professionals involved

Name:
Telephone:
Address:
Role:

Name:
Telephone:
Address:
Role:

Name:
Telephone:
Address:
Role:

Assessment summary

Summary of presence of eating disorder behaviours

Body Image concerns	
Restricted Eating	
Bingeing	
Vomiting	
Compulsive exercise	
Other weight control behaviours	

Summary of other mental health difficulties (anxiety, depression, self-harm, suicidal behaviour)

Summary of impact on functioning

Relationships	
Vocational (study/ work)	

*DSM Diagnosis/ provisional diagnosis :*_____

Use table to assist with considering which diagnosis category best fits the client's presentation

DSM 5 Eating Disorder Diagnosis

Anorexia Nervosa (AN)	•Restriction of **Energy Intake**, leading to low body weight •Intense **Fear of Weight Gain/Fatness** •**Self-evaluation highly influenced by Weight/Shape**
Bulimia Nervosa (BN)	•Recurrent **Binge Eating** •Recurrent **Compensatory Behaviours** (vomitting, fasting, excessive exercise etc) •**Self-evaluation highly influenced by Weight/Shape**
Binge Eating Disorder (BED)	•Recurrent **Binge Eating** •Marked **Distress/Guilt** about Binges
OSFED (Other Specified Feeding or Eating Disorder)	•**Mixed behaviours / presentation** •Significant impact on functioning
Atypical Anorexia Nervosa (AAN) (OSFED)	•Restriction of **Energy Intake** (body weight in a healthy range**)** •Intense **Fear of Weight Gain/Fatness** •**Self-evaluation highly influenced by Weight/Shape**
Avoidant/Restrictive Food Intake Disorder	•**Weight loss**, **failure to grow** or **malnutrition** with associated medical risk, as a consequence of **inadequate food intake** •Restricted eating (quantity or variety)

Physical Risk in Suspected Eating Disorders: Mental Health Clinician Response Guide

Referral requirement and recommendations

Is a referral to medical and/or mental health clinicians required? Use figure below to guide referral decision.
Has assessment summary been provided to medical/ mental health clinician?
NOTE: All Anorexia or Anorexia like presentations require an urgent medical assessment and referral response

Victorian System of Care for People with Eating Disorders