The Charis Center for Eating Disorders
Indiana University Health

CHARIS CENTER
Eating Disorder Questionnaire

Patient Name: _____ **Date of Birth**:_____

Medical History

If applicable, name of provider who prescribes psychiatric medications (Primary Care Provider or Psychiatrist):

_____

1. Has your adolescent had any significant family traumas? [ ] Yes [ ] No
   If yes, please explain?

2. Does your adolescent have any personal history or abuse? [ ] Yes [ ] No
   If yes, for what? Please describe.

3. Is your adolescent under a doctor's care for any medical conditions? [ ] Yes [ ] No
   If yes, for what? Please list conditions and treating provider.

4. Has your adolescent ever been hospitalized for medical reasons? [ ] Yes [ ] No
   If yes, for what? When? Where?

5. Has your adolescent ever had any surgery? [ ] Yes [ ] No
   If yes, for what? When?

6. Does your adolescent have any allergies (drug or environmental)? [ ] Yes [ ] No
   If yes, please list allergies and reactions.

7. What concerns do you have about your adolescent's health (physical, emotional, school, other)?

8. What do you see as your adolescent's strengths?