The Charis Center for Eating Disorders
Indiana University Health

CHARIS CENTER
Eating Disorder Questionnaire

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

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

_____

1. Have you had any significant family traumas? [ ] Yes [ ] No
   If yes, please explain?

2. Have you had any personal history of abuse? [ ] Yes [ ] No
   If yes, for what? Please describe.

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

4. Have you ever been hospitalized for medical reasons? [ ] Yes [ ] No
   If yes, for what? When? Where?

5. Have you had any surgeries? [ ] Yes [ ] No
   If yes, for what? When?

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

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

8. What do you see as your strengths?