Working with your Health Care Professional

Developed by Eating Disorder Support Network of Alberta (EDSNA)

www.EatingDisorderSupportNetworkofAlberta.com

Ask your doctor, first of all:

What is your experience with eating disorders? Do you feel comfortable working with us or would you rather refer us to a colleague? _____

If you feel it is appropriate to proceed:

Here are the concerns I/we would like to share (tick any that apply):

☐ weight loss/gain ☐ withdrawing/isolating ☐ restricting food ☐ fear of gaining weight

☐ body dissatisfaction ☐ rigid thinking ☐ purging ☐ obsessive exercising

☐ bingeing ☐ fear/avoidance of certain foods ☐ depression ☐ anxiety ☐ self-harm

☐ suicidal thoughts ☐ abuse of laxatives ☐ sleep disturbances ☐ inability to concentrate

☐ emotional outbursts ☐ intense feelings of shame, self-loathing ☐ recent vegetarian/vegan

☐ sudden, new focus on recipes/ cooking/health ☐ cutting food into tiny pieces

☐ frequent trips to bathroom after eating ☐ disappearances of large amounts of food

☐ obsession with gaining more muscle mass ☐ possible use of steroids

☐ substance abuse ☐ impulsivity ☐ reckless behaviour

Some more details (use additional paper, if needed):

Changes in weight: from _____ to _____ in _____months

Suggestion: Bring pictures before onset of illness to help illustrate changes.

Changes in behaviour: _____

_____

Changes in mood: _____

_____

Physical symptoms that have I/we have noticed - tick all that apply

☐ Feeling cold ☐ dizziness, fainting ☐ changes to skin/hair ☐ acetone smell of breath

☐ Loss of enamel/discolouration of teeth ☐ puffiness around jaw/cheeks ☐ OCD-like tics

☐ Loss of energy ☐ fluid retention ☐ loss of menstruation ☐ constipation, bloating

☐ Very pale ☐ chewing gum all the time ☐ inability to sit still, agitation

☐ New, downy hair all over body ☐ Other:_____

Physical Examination by doctor:

NOTE: Please ask doctor to do a "blind weight"--check weight by asking patient to turn around so they don't see (or hear) the number. Also, be sure to empty pockets, remove heavy clothing, belts, etc.

Heart rate: ____ Throat/teeth: _____ Body temperature:_____ Weight: _____

Blood pressure: _____ Physical signs of self-harm: _____ Other:_____

Deviation from pediatric growth curve (if available/applicable):_____

Please use the SCOFF Questionnaire, developed by doctors in the UK to screen for anorexia or bulimia.
(Parents may leave the room for this questionnaire to allow child to be more honest in answers.)

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Yes to 2 of above = high likelihood anorexia or bulimia Number of yes answers: _____

Additional lab tests (ask doctor which ones apply):

☐ Blood test (potassium, magnesium, iron, estrogen ☐ ECG, to test heart function

☐ Urinalysis to check kidney function ☐ cholesterol, gall bladder, diabetes (Binge eating)

☐ Blood sugar levels ☐ bone density

Other: _____

QUESTIONS: (write them down here, as you may forget them in the appointment)

NEXT STEPS:

Referrals: _____

Treatment options: _____

Recommended course of action: _____

Next appointment: _____