**Working with your Health Care Professional**

*Developed by Eating Disorder Support Network of Alberta (EDSNA)*

[*www.EDSNA.ca*](http://www.edsna.ca/)

# **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 think it’s appropriate to continue:**

My concerns I would like to share with you (check all that apply):

▢ Weight loss/gain ▢ Body dissatisfaction

▢ Withdrawing/isolating ▢ Rigid thinking

▢ Restricting food ▢ Purging

▢ Fear of gaining weight ▢ Obsessive exercise

▢ Eating until you feel ill ▢ Self-harm

▢ Avoiding certain foods ▢ Suicidal thoughts

▢ Depression ▢ Laxative abuse

▢ Anxiety ▢ Sleep disturbances

▢ Inability to concentrate ▢ Sudden new focus on recipes/cooking/health

▢ Recently vegetarian/vegan ▢ Dangerous/reckless behaviour

▢ Obsession with muscle mass ▢ Impulsivity

▢ Steroid use ▢ Drug abuse

▢ Cutting food into little pieces ▢ Aversion to liquids (eg. water)

▢ Large quantities of food disappearing ▢ High consumption of ‘diet’ foods/drinks

▢ Shame/self-loathing ▢ Changes in mood around mealtime

▢ Frequently visiting the bathroom after meals ▢ Skipping meals

▢ Disappearing around mealtimes/not being around for meals ▢ Family history of eating disorders

▢ Feeling self-conscious or uncomfortable in body-conscious clothing ▢ Personal history of eating disorders

▢ Being secretive about meals eaten ▢ Weighing and measuring self

▢ Hyper awareness of appearance (eg. avoid mirrors, avoiding being in pictures, body checking)

▢ Fear of judgement from others about body shape or size ▢ Difficulty eating in social situations

▢ Visiting pro-ED websites or social media pages

**Dietary/Lifestyle Changes** *(tick any that apply)***:**

▢ Vegan

▢ Vegetarian

▢ Plant based (or mostly plant based)

▢ ‘Clean eating’ (eg. raw, mostly raw, Whole30, only organic)

▢ Other diet (eg. keto, paleo, intermittent fasting, Southbeach, Noom, Weight Watchers, meal replacements)

▢ Engaging in cleanses (eg. tea, juice)

▢ Use of calorie or activity tracking software/apps

**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:**

▢ Self harm or self injurious behaviour (eg. cutting, exposure to extreme temperature, piercing, beating/hitting, slapping)

▢ Withdrawing from social activities

▢ Fatigue

▢ Insomnia

▢ Reckless behaviour (option to specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Changes in mood:**

▢ Depression or depressive episodes

▢ Increase in anxiety

▢ Panic attacks

▢ Thoughts of suicide

▢ History of mental health diagnosis (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Obsessive or cyclical thoughts

▢ Intrusive thoughts

**Physical symptoms we’ve noticed:**

▢ Feeling cold ▢ Retaining water

▢ Dizziness/fainting ▢ Loss of period

▢ Changes in skin/hair ▢ Constipation/bloating

▢ Acetone smell of breath ▢ Very pale

▢ Loss of enamel/discoloration of teeth ▢ Constantly chewing gum

▢ Puffiness around cheeks/jaw ▢ Inability to stay still, agitation

▢ OCD-like tics ▢ New, downy hair all over body

▢ Loss of energy ▢ Rarely/ever feeling hungry

Autre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Exam:**

*NOTE: Please ask the doctor to do a “blind weight”--check weight by asking the 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:

Body temperature:

Weight:

Blood pressure:

Physical signs of self harm:

Deviation from pediatric growth chart (if applicable):

Other:

# 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 their child to be more honest in answers.)*

**SCOFF QUESTIONNAIRE***.*

[yes/no] Do you make yourself **S**ick because you feel uncomfortably full?

[yes/no] Do you worry that you have lost **C**ontrol over how much you eat?

[yes/no] Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?

[yes/no] Do you believe yourself to be **F**at when others say you are too thin?

[yes/no] Would you say that **F**ood controls your life?

**Result: \_\_\_\_\_\_\_\_\_\_\_\_** *(Every “yes” counts for one point)***.**

*A result of 2 or more indicates that a person is likely suffering from anorexia or bulimia.*

**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, gallbladder, diabetes (for binge eating):

Blood sugar:

Bone density:

Other:

**Questions** *(write here before your appointment)***:**

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**Next steps:**

Referrals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment options: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended plan of action: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_