Name_____ DOB_____

Eating Disorder Evaluation
Regarding your current eating habits…

Please provide us details regarding your food intake over a typical day. We ask that you list the time, food and/or beverage, and approximate amount consumed in the area below. Be sure to include everything you typically consume over a 24-hour period.

Time	Food or beverage	Approximate amount consumed

Do you have any food allergies or intolerances? Yes/No
If yes, please list_____

Do you consider yourself vegetarian? Yes/No Vegan? Yes/No

If vegetarian, do you include: eggs, milk, fish, yogurt, chicken, soymilk, nuts, peanut butter (please circle).