

# Nova Luna Center

## Eating Disorder Programs

### Eating Disorder Initial Screening

Do you think you have an eating disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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#### Anorexia Nervosa

##### Weight

What is your height: _____	weight: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how much _____
Have you lost weight recently?		<input type="checkbox"/> Normal or Overweight		
What is your weight history		<input type="checkbox"/> Always Overweight		
Do other people consider yo underweight?				<input type="checkbox"/> Yes <input type="checkbox"/> No

##### Intake Restriction

Do you diet all the time? Do you avoid fats? Do you avoid sweets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>

##### Fear of Fat

Are you afraid of being fat? Do you still fear being fat, even if you have lost weight? If you reached your goal weight, would you still restrict your food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>

##### Body Distortion

Do you consider yourself:	<input type="checkbox"/> Overweight	<input type="checkbox"/> Average	<input type="checkbox"/> Underweight
Distortion present based on visual observation? Do you dislike the way your body looks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>

##### Amennorrhea

When was your last period? More than a month ago? Within a Month?

Have your periods been irregular or absent for more than 3 months? Are you on hormone therapy (BCP) to regulate periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>

#### Bulimia Nervosa

##### Binge Eating

Do you have a problem with binge eating? On a binge, do you eat more than most people would in similar circumstances? Do you feel out of control over eating when bingeing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>
	Yes	<input type="checkbox"/> No	<input type="checkbox"/>

##### Purging

Do you do anything to compensate for bingeing to prevent weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	What?
Do you induce vomiting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	How often?

Do you use laxatives? Do you use diuretics? Do you use diet pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes No <input type="checkbox"/>	How many? How often? How many? How often? How many? How often?
Do you exercise more than 3 times per week?		
Do you fast to compensate for bingeing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Over-Concern with Body Shape and Weight**

**Medical Side Effects**

Is your weight or body shape of primary importance in how you value yourself? Does your body image matter more to you than other aspects of your self?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Do you have any of the following?**

<input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Dizziness	<input type="checkbox"/> Chest <input type="checkbox"/> Vomiting	<input type="checkbox"/> Muscle Pain <input type="checkbox"/> Extreme Fatigue	<input type="checkbox"/> Shortness of Breath
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