

# 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			<input type="checkbox"/> Always Overweight
What is your weight history					
Do other people consider yo underweight?				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Intake Restriction**

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

**Fear of Fat**

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

**Body Distortion**

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

**Amennorrhhea**

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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on hormone therapy (BCP) to regulate periods?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Bulimia Nervosa**

**Binge Eating**

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

**Purging**

Do you do anything to compensate for bingeing to prevent weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What?
Do you induce vomiting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	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 <input type="checkbox"/> No	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"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
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**Do you have any of the following?**

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