Central Region Eating Disorder Services (CREDS)

SELF ASSESSMENT FORM

Please try to answer the questions as fully as possible even if they do not exactly describe your experience

---

General Information

Today's date: _ _ _ _ _ _ _ _ _ _ _ _ _ _   Name: _

Date of Birth: _ _ _ _ _ _ _ _ _ _ _ _ _ _   Previous names: _

Address: _

Country of Birth: _ _ _ _ _ _ _ _ _ _ _ _ _   Number of children/dependants: _ _ _ _ _ _ _ _ _ _ _ _

Are you a New Zealand resident? ☐ yes ☐ no *(If no)* Residency status: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

GP name, details: _

Allergies: _

_ _

Medications: _

_ _

Ethnicity

Please ✓ one box that best describes your ethnicity:

☐ NZ Maori
☐ Other European
☐ Fijian
☐ Samoan
☐ Tongan
☐ South East Asian
☐ Chinese
☐ Latin American/Hispanic
☐ Middle Eastern
☐ NZ European/Pakeha
☐ Cook Island Maori
☐ Niuean
☐ Tokelauan
☐ Other Pacific Nation
☐ Indian
☐ Other Asian
☐ African
☐ Other *[please state]*

Contact details

At times we may need to leave you a message – please ✓ the type of message you are comfortable with us leaving.

Day: _ _ _ _ _ _ _ _ _ _   ☐ *Full message*   ☐ *First name and telephone number only*

© Central Region Eating Disorder Services

Evening: _ _ _ _ _ _ _ _ _ ☐ *Full message* ☐ *First name and telephone number only*

Cellphone: _ _ _ _ _ _ _ _ _ ☐ *Full message* ☐ *First name and telephone number only*

Email: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Please ✓ your preferred method of contact: ☐ Phone call
☐ Email message

When is the best time to contact you? *(We are open Mon-Fri 9.00 am –5.00 pm)* _ _ _ _ _ _ _ _ _ _ _ _ _ _

1. Next of Kin

Please provide the name and contact details of the person we may contact in an emergency.

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Contact details: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Relationship to you: _

Previous history with our service

Have you had previous contact with CREDS? ☐ yes ☐ no

If yes, when? _

Who did you see? _

If possible, do you want to see them again? _

How did you hear about our services? _

Body image

How do you feel about the way that you look? What do you think about your body and your weight?

_ _

_ _

_ _

_ _

Weight and Height

How much do you weigh? *(If you don't know, - what clothes size do you wear? What do other people say about your size?)*

_ _

_ _

How tall are you?

© Central Region Eating Disorder Services

_ _

_ _

Tell us about any weight changes in the last 2 years:

_ _

_ _

For women

Are you still having your periods? ☐ yes ☐ no
Do you currently take contraceptive pills? ☐ yes ☐ no

Diet

Are you limiting what you eat? ☐ yes ☐ no

Are you trying to lose weight? ☐ yes ☐ no

What do you eat in a normal day? *(if each day is very different, please give us a few examples – please be specific, i.e. type of food and amount)*

Breakfast:
Morning Tea:
Lunch:
Afternoon Tea:
Dinner:
Snacks:
Any other food eaten outside of these meals *(please include grazing)*:

Comments: _

_ _

Do you think of foods as being good or bad? *(please give examples)*

_ _

_ _

_ _

Binge eating

Do you sometimes eat large quantities of food? ☐ yes ☐ no

If yes, please answer the following:

What do you eat? *(please be specific, i.e. type of food and amount)*

_ _

_ _

© Central Region Eating Disorder Services

How long do you eat for? ____

____

When do you binge eat? ____

____

How often do you binge eat? ____

____

How long have you been doing this for? ________________________________

____

Do you eat constantly during the day? ☐ yes ☐ no

If yes, what do you eat? *(please be specific, i.e. type of food and amount)*

____

____

Do you limit your food intake after binge eating? ____________________________

____

____

Purging

Do you ever make yourself sick/vomit? ☐ yes ☐ no

If yes, how often and when? (*i.e. after a binge?/"normal" meal?/"bad" food?)*

____

____

Do you ever use laxatives? ☐ yes ☐ no

If yes, how many, how often, and when ? *(i.e. after a binge?/"normal" meal?/"bad" food?)*

____

____

If you binge eat, how often do you use laxatives or vomit afterwards?

____

____

© Central Region Eating Disorder Services

How much do you exercise in response to your eating behaviour? *(Please be specific)*

_ _

_ _

History

How long have you been experiencing difficulties with your food and weight?

_ _

_ _

Are you aware of anything that may have led to you having these difficulties?

_ _

_ _

Please describe how you have been feeling recently:

_ _

_ _

Do you have any other physical health issues? ☐ yes ☐ no

If yes, please describe: _

_ _

Alcohol and Drugs

Do you drink alcohol? ☐ yes ☐ no

If yes, please describe: *(Please be specific – how much, how often etc, types of alcohol)*

_ _

_ _

_ _

_ _

Do you use drugs? ☐ yes ☐ no

If yes, please describe: *(Please be specific – types of drugs, how often you use, how much etc)*

_ _

_ _

Support services *(Please be specific)*

© Central Region Eating Disorder Services

Are you currently seeing a mental health professional
(e.g. a therapist or psychologist) or a dietitian?

☐ yes ☐ no

If yes – who and why? _

_ _

Have you in the past? ☐ yes ☐ no

If yes – who and why? _

_ _

Are you currently on any medication? ☐ yes ☐ no

If yes, please describe: _

_ _

Does anyone else know about your eating behaviours? ☐ yes ☐ no

If yes, who? _

_ _

Please state anything else you think it is important for us to know:

_ _

_ _

_ _

_ _

_ _

Thank you for completing this self-assessment.

If you were assisted in completing this form-please note here who assisted you and their relationship to you

....

Please return this form to your CAMHS or CMHT clinician / case manager.

© Central Region Eating Disorder Services