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

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

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)* _ _ _ _ _ _ _ _ _ _ _ _ _

Would you like to receive text or email appointment reminders?
Some areas are starting to send appointment reminders by text and email.

1. Would you like to receive appointment reminders by text or email when this is available? (✓) Yes ☐ , No ☐
If yes,
What is your preferred appointment reminder method? (✓) Text reminder ☐ , Email reminder ☐

Reminders, when available, can also be sent to your next of kin/emergency contact people if you would like.

2. Would you like your next of kin/ contact person to receive appointment reminders for your appointments when this is available?(✓) Yes ☐ , No ☐
If yes,
Which contact person (below) would you like to have receive the reminders: (✓) **1.** ☐ **, 2.** ☐**, 3.** ☐

What is their preferred reminder method? (✓) Text reminder ☐ , Email reminder ☐

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: _

2. 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?

_ _

_ _

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 amounts of food? ☐ yes ☐ no

If yes, please answer the following:

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

_ _

_ _

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/after a "normal" meal/after eating "bad" food?)*

_ _

_ _

Do you ever use laxatives, or other drugs to compensate for eating? ☐ yes ☐ no

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

_ _

_ _

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

_ _

_ _

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)*

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

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Please post it back to us as soon as possible;

CREDS, Private Bag 31 907, Lower Hutt

Or you may email to:

creds@mhaids.health.nz