Eating Behavior Self-Assessment

Dartmouth College Eating Behavior Self-Assessment

This self-assessment is only an indicator. It is not fool-proof. Regardless of your score, if you feel you need or want an evaluation please do not hesitate to make an appointment at Dartmouth College Health Service for a referral to the nutritionist.

Appointments are available to all enrolled Dartmouth students for these and other concerns, including questions about how to help friends.

If the self-assessment indicates disordered eating or that an evaluation is recommended, please call the **Counseling Center** (603-646-9442) to set up an appointment for a triage appointment. The counselor you meet with can provide a referral to the nutritionist. If you would like to see a medical clinician, please call 603-646-9401 for an appointment in the **Primary Care Outpatient Clinic**.

1. Do you worry about gaining weight?
   (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
2. Do you avoid foods because of the fat, carbohydrate, or sugar content in them?
   (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
3. How often do you think about wanting to be thinner?
   (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
4. Are you bothered by the thought of having fat on your body?
   (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
5. Do you feel guilty after eating?
   (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
6. Do you feel that food controls your life?
   (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
7. During the past six months, have you had episodes when both of the following applied: a) You have eaten an unusually large amount of food within a two hour period, and b) you have felt unable to control how much you were eating within these periods?
   (A) Never (B) Less than once a month (C) About 1/month (D) About 1/week (E) 2+/week

   During the past six months, have you ever done any of the following:
8. Self-induced vomiting in an attempt to control your weight?
   (A) Never (B) Less than once a month (C) About 1/month (D) About 1/week (E) 2+/week
9. Taken laxatives in an attempt to control your weight?
   (A) Never (B) Less than once a month (C) About 1/month (D) About 1/week (E) 2+/week
10. Restricted your eating in an attempt to control your weight? Restrictive eating = eating less than 500 calories a day or skipping 2 or more meals a day.

(A) Never (B) Less than once a month (C) About 1/month (D) About 1/week (E) 2+/week

11. Taken diuretics (water pills) in an attempt to control your weight?
    (A) Never (B) Less than once a month (C) About 1/month (D) About 1/week (E) 2+/week
12. Exercised in an attempt to control your weight?
    (A) Never (B) About 1 hour/day (C) About 2 hours/day (D) About 3 hours/day (E) More than 3 hours/day
13. During the past six months, have you exercised to control your weight even when injured, sick, or against a doctor's orders?
    (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
14. During the past six months, has exercising to control your weight significantly interfered with other activities?
    (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time

Do your concerns or behaviors about eating or weight interfere with your:

15. Relationships (e.g., Avoiding family members and /or friends to have time and privacy for bingeing, purging, or exercising)?
    (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
16. Academic/work performance?
    (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
17. Do your concerns or behaviors about eating or weight cause you a great deal of distress?
    (A) Never or Rarely (B) Some of the time (C) Much of the time (D) All of the time
18. Have you ever been diagnosed with or treated for an eating disorder? No Yes
19. Women only: How many menstrual periods have you had in the past year?
    (A) 9 or more (B) 7-8 (C) 5-6 (D) 4 or less

SELF-ASSESSMENT SCORING: Give yourself points for each of the following:

Question #	Answer	# Points	Question #	Answer	# Points
1	B	1	9	B	1
1	C or D	2	9	C or D or E	6
2	B	1	10	B	1
2	C or D	2	10	C or D or E	6
3	B	1	11	B	1
3	C or D	2	11	C or D	6
4	B	1	12	C or D	6
4	C or D	2	13	C or D	6
5	B	1	14	C or D	6
5	C or D	2	15	C or D	6
6	B	1	16	C or D	6
6	C or D	6	17	C or D	6

7	B	1	18	Yes	4
7	C or D or E	6	19	B	2
8	B	1	19	C	4
8	C or D or E	6	19	D	6

Total Points = _____

If you scored:

2-5 = May indicate disordered eating. Please consider an evaluation.
6-15 = Evaluation recommended.
16 or above or if any of the following are true, then urgent evaluation recommended. Please call today for an appointment.

- Your weight is considered by yourself or others to be low.
- You use ipecac.
- You vomit frequently (3 times or more per day).
- You take laxatives daily.
- You are unable to work or go to class.
- You feel severely depressed or suicidal.

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Adapted by K. Heidi Fishman, EdD and Marcia Herrin, EdD, Dartmouth College Eating Disorders Treatment Team with permission from The National Eating Disorders Screening Program Screening Questionnaire, Harvard Eating Disorders Center, 1996.