# ABOUT ME

**NAME:** **DATE:**

## Readiness for Change:

- Where I am in my journey: pre-contemplation, contemplation, preparation, action, maintenance, relapse.
- My insight into illness/eating disorder (0-10), 10=HIGH _____
- My motivation to work towards recovery (0-10) 10= HIGH_____

3 things I would like you to know about me

______________________ ______________________ ______________________

My triggers are:

______________________

______________________

______________________

______________________

My main concerns/difficulties are:

______________________

______________________

______________________

I am motivated by

______________________

______________________

In my care and recovery, it is important to:

______________________

______________________

______________________

______________________

______________________

When did your disorder start, & what triggered it?

______________________

______________________

______________________

______________________

______________________

How can people support me better:

______________________

______________________

## Diagnosis:

- Date of Diagnosis:
- Anorexia
- Bulemia
- Binge Eating Disorder
- Other ________
- NO official diagnosis
- Other ________

Pertinent Hx

Last hospitalization

______________

Other:

______________

## Purging:

- Vomitting, if YES, specify frequency______________________________
- Laxative use, if YES, specify amt. and frequency ________________
- Use of diet pills or stimulants, if YES, explain ____________________
- Fasting:
- Binging, if YES, specify (frequency/cycle) _________________________

## Behaviours:

- Currently, I do not feel safe sharing the specifics of my behaviours with you
- Changes in eating, if YES, ______________________________
- Hunger supression: caffeine, smoking, drugs, excessive water intake

**Food Behaviours:** (use back of sheet if necessary)

__________________________________________________________

__________________________________________________________

__________________________________________________________

## Medications:

OTC meds. or supplements

__________________________________

__________________________________

__________________________________

__________________________________

__________________________________

__________________________________

Medical marijuana: NO/YES

## Body Image:

- Body checking/weighing
- Preoccupation with weight or shape
- Goal of weight loss: ______

## Fear foods:

__________________________________

__________________________________

__________________________________

__________________________________

## Neurological:

- headaches
- seizures
- blackouts

## Cardiovascular:

- dizziness
- blackouts
- I feel faint when I get up quickly
- chest pain
- palpitations
- swelling in my hands & feet

## Mental Health:

Substance usage/abuse/addiction.
IF yes, specify__________
Know self-harm behaviours: If YES, specify_________

- Anxiety
- Depression
- OCD
- PTSD
- BPD
- Other:

## Gastrointestinal:

- Vomitting, with/without blood
- constipation
- diarrhea
- abdominal pain
- nausea
- heart burn

## Sleep Patterns:

- Insomnia
- difficulty falling asleep
- difficulty staying asleep
- nightmares
- sleepwalking
- sleep apnea

## Musculosketal:

- weakness
- cramping, if YES, where_____
- Pain, if YES, where_________

## Dental History:

- Last dental exam:
- My teeth are healty
- My teeth are ___

## Hair/Skin:

- hair loss
- dry skin/dry brittle nails
- Lanugo (fine hair all ove rmy body)

## Gynecological:

- I do/don't have periods
- Regular/irregular
- My cycles are ___ days
- Period is painful: yes/no
- My bleeding is: ______

## Anything Else:

# Reflections Of The Day

| Things that went well |
| --- |
| |

| Changes I will make |
| --- |
| |

| Notes |
| --- |
| |