

**Portland Dialectical Behavior Therapy Program, PC
PME Additional Assessment**

Name: _____

Date: _____

Weight history:

Current body weight	Current height	Body mass index	% Ideal body weight
Highest stable weight before ED	Highest weight/year	Lowest weight/year	Age of onset of ED

General history of weight variations before and after the eating disorder.

Perception of ideal body weight without disordered eating.

Typical day of eating:

List typical times of meals, types/amounts of foods, compensatory behaviors.

Breakfast	
Lunch	
Dinner	
Snacks	

Weight control behaviors:

Type	Frequency	Description of behavior
Dieting/fasting		
Self induced vomiting		
Spitting food		
Exercise/activity		

Substance misuse to control weight:

Type	Frequency	Description of behavior
Laxatives/enemas		
Diuretics		
Emetics		
Stimulants/diet pills		
Street drugs		

Binge eating:

Frequency of binge eating over the past three months (note fluctuation and longest period of abstinence):

Binge food and amounts (foods eaten and those that trigger episodes):

Typical times and settings for binge eating:

Mood:

Before	During	After

Experience loss of control during a binge? No Yes

Restrictive Eating

Pattern of intake when adhering to restrictive pattern:

Estimated caloric intake when adhering to restrictive pattern:

Specific dietary “rules”:

Mood:

Before	During	After

Attitude toward weight and shape:

Judgments about your body (whole body and specific regions):

How much weight do you feel you have to lose:

Frequency of weighing, weight preoccupation, intrusive thoughts about weight, response to weighing:

Frequency of body checking and body avoidance, intrusive thoughts about body, response to body checking:

Level/frequency of comparisons made to others:

Perception of others’ attitudes about your body weight:

Physical signs and symptoms:

Absent menses, # of months _____	<input type="checkbox"/> Current <input type="checkbox"/> Past	Abdominal pain/bloating	<input type="checkbox"/> Current <input type="checkbox"/> Past
Constipation	<input type="checkbox"/> Current <input type="checkbox"/> Past	Swollen cheeks	<input type="checkbox"/> Current <input type="checkbox"/> Past
Cold intolerance	<input type="checkbox"/> Current <input type="checkbox"/> Past	Salivary gland hypertrophy	<input type="checkbox"/> Current <input type="checkbox"/> Past
Dental problems	<input type="checkbox"/> Current <input type="checkbox"/> Past	Weakness	<input type="checkbox"/> Current <input type="checkbox"/> Past
Edema	<input type="checkbox"/> Current <input type="checkbox"/> Past	Lesions on hand	<input type="checkbox"/> Current <input type="checkbox"/> Past
Dry/yellow/orange skin	<input type="checkbox"/> Current <input type="checkbox"/> Past	Difficulty sleeping	<input type="checkbox"/> Current <input type="checkbox"/> Past
Hair loss	<input type="checkbox"/> Current <input type="checkbox"/> Past	Low weight	<input type="checkbox"/> Current <input type="checkbox"/> Past
Lanugo	<input type="checkbox"/> Current <input type="checkbox"/> Past		

Medical Findings

Bradycardia	<input type="checkbox"/> Current <input type="checkbox"/> Past	Low or elevated glucose (circle one)	<input type="checkbox"/> Current <input type="checkbox"/> Past
Hypertension	<input type="checkbox"/> Current <input type="checkbox"/> Past	Irregular potassium	<input type="checkbox"/> Current <input type="checkbox"/> Past
Low body temperature	<input type="checkbox"/> Current <input type="checkbox"/> Past	Osteopenia/osteoporosis	<input type="checkbox"/> Current <input type="checkbox"/> Past
Orthostatic to BP	<input type="checkbox"/> Current <input type="checkbox"/> Past	Electrolyte imbalance	<input type="checkbox"/> Current <input type="checkbox"/> Past
Orthostatic to HR	<input type="checkbox"/> Current <input type="checkbox"/> Past	Irregular liver enzymes	<input type="checkbox"/> Current <input type="checkbox"/> Past
Iron deficiency anemia	<input type="checkbox"/> Current <input type="checkbox"/> Past	Other: _____	<input type="checkbox"/> Current <input type="checkbox"/> Past

Behavioral/Emotional Symptoms

Agitation	<input type="checkbox"/> Current <input type="checkbox"/> Past	Denial of illness	<input type="checkbox"/> Current <input type="checkbox"/> Past
Irritability	<input type="checkbox"/> Current <input type="checkbox"/> Past		