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Eating Disorder Questionnaire - Adolescent

Name: _____

Education Level: _____ Occupation: _____

Date of Birth: _____ Marital Status: _____

Children:

Name	Age

When did you first notice your child was having difficulties with an eating disorder?

Please describe the eating-disordered behaviors you have witnessed and/or suspected with your child. Please differentiate between what you have actually seen from what you suspect or have hear from others.

Have you spoken with your child regarding your concern? If so, how has your child reacted? If you have not spoken, why?

Have others approached you with concerns for your child? Yes _____ No _____ If yes, please list those people, and state their concerns (as stated to you):

What impact, if any, has your child's eating disorder had on your family system? Have you noticed changes within the family system either prior to, or since, the development of your child's eating issues?

In your opinion, what do you believe your child has developed an eating disorder? (Please check all those that apply):

✓		✓	
	teasing about appearance		difficulty coping with stresses(s)
	problems at school/work		obsessive/compulsive tendencies
	media influences		relational issues with friends
	conflicts between you and your spouse		leaving home/separation
	conflicts between siblings		issues with sexuality
	conflicts between you/your spouse, and your child		difficult sexual experience
	puberty and assoc. changes		family difficulties
	medical reasons (illness/operation)		prolonged period of dieting
	depression		recommendation of weight loss by parent, physician, coach, other
	loss/divorce		

Other reasons (please state):

Please describe the relationship you have with your child:

Please describe the relationship your child has with your spouse/partner:

Please describe the relationship your child has with his/her siblings

Whose initiative was it to seek out treatment for your child?

How willing are you to become involved in your child's treatment (including family therapy):

Very Willing: _____ Somewhat Willing: _____ Not at all Willing: _____

Please describe your child's developmental milestones, as well as strengths and weaknesses (socially, academically, physically, emotionally):

Were there other stresses, losses, or difficult experiences that coincided with your child's development of an eating disorder? Yes _____ No _____ If yes, please describe:

Family History:

Please note family members that have experienced the following:

<i>Illness</i>	<i>Number of Persons</i>	<i>Relationship to Child</i>
Ulcers		
Colitis		
Asthma		
Anxiety		
Depression		
Manic Depressive (Bipolar Disorder)		
Alcoholism		
Drug Addition		
Anorexia Nervosa		
Bulimia		
Compulsive Eating		
Obesity		
Diabetes		
Obsessive Compulsive Disorder		
Learning Disorders		
Suicide Attempts		

Please list any questions you would like addressed concerning your child and treatment planning (as well as questions you have regarding eating disorders):
