Living Hope
Eating Disorder Treatment Center

RESIDENTIAL TREATMENT CENTER PATIENT DISCHARGE

PATIENT NAME: _____ DATE OF DISCHARGE: _____

DISCHARGE SURVEY

Please indicate whether you feel Living Hope Eating Disorder Treatment Center provided either "Satisfactory" or "Unsatisfactory" service for each number listed below.

1.	Physician services received	☐ Satisfactory	☐ Unsatisfactory
2.	Dietitian services received	☐ Satisfactory	☐ Unsatisfactory
3.	Counseling services received	☐ Satisfactory	☐ Unsatisfactory
4.	Art Therapy services received	☐ Satisfactory	☐ Unsatisfactory
5.	Medical assistant services received	☐ Satisfactory	☐ Unsatisfactory
6.	Group sessions	☐ Satisfactory	☐ Unsatisfactory
7.	Family group sessions	☐ Satisfactory	☐ Unsatisfactory
8.	Cleanliness of the environment	☐ Satisfactory	☐ Unsatisfactory

Please answer each of the following questions in the space provided. Should you require more room, you may use the back side of this page.

9. What was the most helpful part of the program?

_____

_____

_____

_____

10. What, if anything, would you like to see changed about the program?

_____

_____

_____

_____

11. Additional comments:

_____

_____

_____

_____

_____

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CONSENT FOR CONTACT AFTER DISCHARGE

_____ I give consent to Living Hope Eating Disorder Treatment Center to contact my after I have been discharged from the program.

_____ I do not give consent to Living Hope Eating Disorder Treatment Center contacting me after I have discharged from the program, except as it pertains to billing.

_____ _____

Patient Signature Date

_____

Patient Printed Name

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EATING QUESTIONAIRE

INSTRUCTIONS: The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully and do not leave any question unanswered. Thank you.

QUESTIONS 1 to 12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

	On how many of the past 28 days…	No Days	1-5 Days	6-12 Days	13-15 Days	16-22 Days	23-27 Days	Every Day
1.	Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2.	Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3.	Have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4.	Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you succeeded)?	0	1	2	3	4	5	6
5.	Have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6.	Have you had a definite desire to have a totally flat stomach?	0	1	2	3	4	5	6
7.	Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8.	Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9.	Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
10.	Have you had a definite fear of losing control and over eating?	0	1	2	3	4	5	6
11.	Have you felt fat?	0	1	2	3	4	5	6
12.	Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

QUESTIONS 13 to 18: Please fill in the appropriate number in the boxes on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past four weeks (28 days)…

13. How many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)? _____
14. On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)? _____
15. How many **DAYS** have such episodes of overeating occurred (i.e., you have eaten an unusually large amount of food and have had a sense of loss of control at the time)? _____
16. How many times have you made yourself sick (vomit) as a means of controlling your shape or weight? _____
17. How many times have you taken laxatives as a means of controlling your shape or weight? _____
18. How many times have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat or to burn off calories? _____

QUESTIONS 19 to 21: Please circle the appropriate number on the right. **Please note that for these questions the term "binge eating" means: eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.**

19.	Over the past 28 days, on how many days have you eaten in secret (i.e. furtively)? … Do not count episodes of binge eating	No Days 0	1-5 Days 1	6-12 Days 2	13-15 Days 3	16-22 Days 4	23-27 Days 5	Every Day 6
20.	On what proportion of the times that you have eaten have you felt guilty (felt that you've done wrong) because of its effect on your shape or weight? … Do not count episodes of binge eating	None of the times 0	A few of the Times 1	Less than half 2	Half of the times 3	More than half 4	Most of the time 5	Every Time 6
21.	Over the past 28 days, how concerned have you been about other people seeing you eat? … Do not count episodes of binge eating	Not at all 0	1	Slightly 2	3	Moderately 4	5	Markedly 6

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QUESTIONS 22 to 28: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days).

	Over the past 28 days…	**Not At All**		**Slightly**		**Moderately**		**Markedly**
22.	Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23.	Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24.	How much would it have upset you if you had been asked to weigh yourself once a week (no more or less often) for the next four weeks?	0	1	2	3	4	5	6
25.	How dissatisfied have you been with your weight?	0	1	2	3	4	5	6
26.	How dissatisfied have you been with your shape?	0	1	2	3	4	5	6
27.	How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, window reflection or while undressing or taking a bath or shower)?	0	1	2	3	4	5	6
28.	How uncomfortable have your felt about others seeing your shape or figure (for example, in communal changing rooms, when swimming or wearing tight clothes)?	0	1	2	3	4	5	6

What is your weight at present? (Please give your best estimate) _____

What is your height? (Please give your best estimate) _____

If female: Over the past three to four months, have you missed any menstrual periods? (circle one) YES NO

If yes, how many have you missed? _____Have you been taking "the pill"? (circle one) YES NO

THANK YOU

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MOOD DISORDER QUESTIONAIRE

INSTRUCTIONS: Please answer each question to the best of your ability.

		YES	NO
1.	Has there ever been a period of time when you were not your usual self and…		
	…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	O	O
	…you were so irritable that you shouted at people or started fights or arguments?	O	O
	…you felt much more self-confident than usual?	O	O
	…you got much less sleep than usual and found you didn't really miss it?	O	O
	…you were much more talkative or spoke much faster than usual?	O	O
	…thoughts raced through your head or you couldn't slow your mind down?	O	O
	…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
	…you had much more energy than usual?	O	O
	…you were much more interested in sex than usual?	O	O
	…you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	O	O
	…spending money got you or your family into trouble?	O	O
2.	If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle only on response.*

No Problem Minor Problem Moderate Problem Serious Problem

4.	Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	O	O
5.	Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

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THE PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Patient's Name: _____Date of Assessment: _____

Please read each statement and circle the answer that most applies to you.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	+	+	+	
Add Totals Together				

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?
    - ☐ Not difficult at all
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

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GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult

Source: Spitzer RL, Kdroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med. 2006; 1092-1097*

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