



PORTLAND DBT INSTITUTE, INC: PME ADDITIONAL ASSESSMENT

Client Name: _____

Date: _____

Weight history:

Current Body Weight:	Current Height:	Body Mass Index (BMI):	% 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		

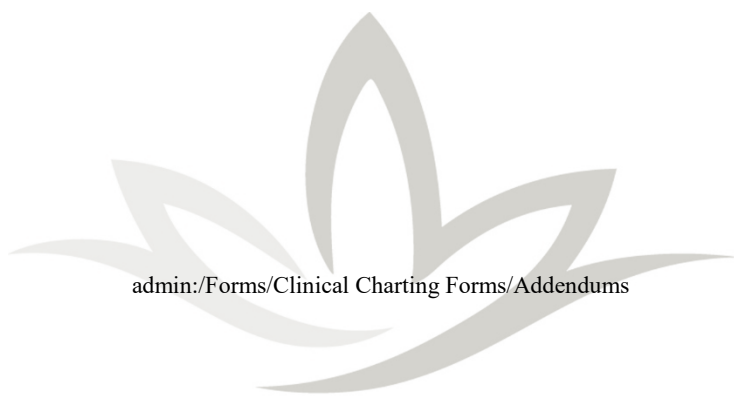
Substance Misuse to Control Weight:

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 (<i>circle one</i>)	<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		