Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

**Part A: Complete the following questions:**

1) Birth Date: Month: Day: Year:  
2) Gender: Male Female

3) Height: Feet: Inches:  
4) Current Weight (lbs.):  
5) Highest Weight (excluding pregnancy):  
6) Lowest Adult Weight:  
7) Ideal Weight:  

**Part B: Check a response for each of the following statements:**

1. Am terrified about being overweight.  
2. Avoid eating when I am hungry.  
3. Find myself preoccupied with food.  
4. Have gone on eating binges where I feel that I may not be able to stop.  
5. Cut my food into small pieces.  
6. Aware of the calorie content of foods that I eat.  
7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)  
8. Feel that others would prefer if I ate more.  
9. Vomit after I have eaten.  
10. Feel extremely guilty after eating.  
11. Am preoccupied with a desire to be thinner.  
12. Think about burning up calories when I exercise.  
13. Other people think that I am too thin.  
14. Am preoccupied with the thought of having fat on my body.  
15. Take longer than others to eat my meals.  
16. Avoid foods with sugar in them.  
17. Eat diet foods.  
18. Feel that food controls my life.  
19. Display self-control around food.  
20. Feel that others pressure me to eat.  
21. Give too much time and thought to food.  
22. Feel uncomfortable after eating sweets.  
23. Engage in dieting behavior.  
24. Like my stomach to be empty.  
25. Have the impulse to vomit after meals.  

**Part C: Behavioral Questions:**

**In the past 6 months have you:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Once a month or less</th>
<th>2-3 times a month</th>
<th>Once a week</th>
<th>2-6 times a week</th>
<th>Once a day or more</th>
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<tbody>
<tr>
<td>A  Gone on eating binges where you feel that you may not be able to stop?</td>
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<td>B  Ever made yourself sick (vomited) to control your weight or shape?</td>
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<td>C  Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?</td>
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<td>D  Exercised more than 60 minutes a day to lose or to control your weight?</td>
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<td>E  Lost 20 pounds or more in the past 6 months</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

* Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control

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