

Client Name: _____ Client DOB: _____

Eating Disorder Screen for Primary Care (ESP)¹

| | YES | NO |
|--|-----|----|
| 1. Are you satisfied with your eating patterns? | | |
| 2. Do you ever eat in secret? | | |
| 3. Does your weight affect the way you feel about yourself? | | |
| 4. Have any members of your family suffered with an eating disorder? | | |
| 5. Do you currently suffer with or have you ever suffered in the past with an eating disorder? | | |

* A “no” to question 1 is considered an abnormal response.

** A “yes” to questions 2-5 are considered abnormal responses.

Any abnormal response indicates that client needs further assessment.

Please contact:

Casey Becker, LMHC
Mended Wing Counseling, LLC
930 E. Brainerd St.
Pensacola FL 32503
www.mendedwingcounseling.com
(617)797-7949
mendedwingcounseling@gmail.com

Client referred by : _____ Contact number: _____

[Four Simple Questions Can Help Screen for Eating Disorders](#). M Cotton, C Ball, P Robinson. J Gen Intern Med. 2003 January; 18(1): 53–56. doi: 10.1046/j.1525-1497.2003.20374.x