Kathryn Fink, MS, RDN, LD, CEDRD
214-850-9573
fax 972-255-7997
kat@confidenceineating.com
www.confidenceineating.com

Treatment History:

Dates of service	Facility	Treated for

Use additional paper as needed

Weight/Diet History

Weight when eating disorder started_____ Highest Weight_____ When?___
Lowest Weight_____ When?___
Tell me a little more about your weight history

_____
_____
_____
_____
_____
_____

Tell me a little more about the disordered behaviors you have used:

Behavior	How often?	When started & Last used

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Any additional information you wish to share or feel is helpful for me to know.