BINGE EATING DIAGNOSTIC FEATURES

Name _______________________________ Date __________________

1. Eating rapidly_____  

2. Eating until uncomfortably full_____  

3. Eating large amounts of food when not hungry_____  

4. Eating alone because of embarrassment over how much one is eating_____  

5. Felling disgust, guilt, or depression after eating_____  

6. Concerns about the long term effects of recurrent binge episodes on body weight and shape_____  

7. Binge at least 2 days a week_____ over 6 months_____  

8. Compensatory behaviors_____  

9. Non specific feeling of tension that is relieved with eating_____  

10. Feeling numb, spaced out, disassociate with eating_____  

11. Current food pattern intake__________________________  

12. Eating interferes with relationship with others_____ with work_____ with feeling good_____.  

13. Experiencing self loathing_______ Disgust with body size_______

Other________________________________________________

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