Eating Disorder Assessment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

An eating disorder assessment is a structured intake evaluation: a validated screener plus DSM-5-TR criterion mapping, eating and weight history at the domain level, and a medical-risk appraisal with a level-of-care rationale, coordinated with medical and nutrition colleagues. The diagnosis, the placement argument, and the collaborative plan all build on it.

Referral context & presenting concerns the client's words come first

Do: record who sent the client and why, the concern in the client's own words, then onset, course, and prior treatment with response.
Pitfall: opening with your formulation; the chief complaint in the client's own language is what a reviewer looks for first.

Screening & standardized measures name it, date it, attribute it, file it

Do: name the instrument, the date, who administered it, and where the scored form is filed; a screener plus a self-report measure fits an intake hour.
Pitfall: a score with no instrument, date, or administrator attached; an unattributed number reads like an incorrectly scored tool to a reviewer.

Eating, weight & behavior history domain level, never counts

Do: record the domains endorsed and denied: restriction, binge episodes, compensatory behaviors, driven exercise, preoccupation.
Pitfall: reproducing weight numbers or behavior counts; the assessment travels further than the measure, so detail stays there, referenced by location.

Medical risk & the handoff the duty is the handoff, not the values

Do: document the domains reviewed (vitals, orthostatics, labs, ECG when indicated), who owns each, the referral, the release, and the results due date.
Pitfall: transcribing lab values and vitals; "workup ordered by Dr. R., results due here by 08/20" shows the duty discharged.

Mental status, co-occurring conditions & suicide risk write the reasoning out

Do: complete a full mental status exam, screen depression, anxiety, trauma, and substance use, and state the suicide-risk findings with reasoning; elevated risk is the base rate.
Pitfall: a checked risk box with no reasoning; checkbox risk assessment sits among the leading documentation-based 90791 denials.

DSM-5-TR diagnosis & severity the criterion trail is the evidence

Do: map the endorsed findings to criteria, state the diagnosis and specifier, and mark it provisional while medical findings or collateral records are pending.
Pitfall: a diagnostic label with no criterion trail; findings that cannot be matched to the billed diagnosis return as CARC 16 and 50 denials.

Level-of-care rationale the paragraph payers actually read

Do: state the recommended level, the criteria considered, and the facts supporting the choice: current status, trajectory, and the medical team's findings.
Pitfall: arguing from a DSM severity band; payer criteria weight physiologic instability and rate of change over any static category.

Collaborative plan & communication undocumented communication did not happen

Do: record therapy modality and frequency, the medical monitoring schedule, the nutrition referral, releases on file, who communicates with whom, and the review date.
Pitfall: "referred to PCP" with no recipient, date, or release; auditors and licensing boards read silence as absence.

Before you sign

- [ ] Chief complaint quoted in the client's words
- [ ] History gives onset, course, prior treatment
- [ ] Every measure named, dated, attributed, filed
- [ ] Handoff shows named physician and workup
- [ ] Release signed; results have a due date
- [ ] Suicide risk carries reasoning and monitoring
- [ ] Level of care argued from status and trajectory
- [ ] Behavior detail stays at domain level

Drafting with AI

Capture 30 seconds of bullets after the interview: the client's words, each measure with date and administrator, domains endorsed and denied, the medical handoff with dates, risk reasoning, provisional diagnosis, level-of-care facts.

"Draft an eating disorder assessment from these bullets, adult self-referred, SCOFF positive and EDE-QS in the clinical range, outpatient level with a same-week medical workup: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

400 to 1,000 words	30 to 60 min by hand	At intake	Team · payers · auditors
typical length	clinical team estimate	and level-of-care decisions	who reads it

Full guide and sample note:
bastiongpt.com/template/eating-disorder-assessment

Eating Disorder Assessment Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): | DOB / age: | Date: | Clinician / credentials:

Referral source: | Reason for referral: | Service: eating disorder assessment

Presenting concerns & history

The concern in the client's own words, quoted briefly; onset, course, prior treatment episodes and response

Screening & standardized measures

Scores stay with the scored form and the medical record; name it, date it, attribute it, file it

Instrument / screener: | Date given: | Administered by: | Filed where:

Additional measure(s):

Eating, weight & behavior history

Domain level only: restriction, binge episodes, compensatory behaviors, driven exercise, food-repertoire narrowing, preoccupation; quantified detail stays in the measure and the medical record

Domains endorsed: | Domains denied:

Weight status and trajectory assessed by (medical record):

Medical risk & handoff

The therapist's duty is the handoff and its follow-through, not the values; results stay in the medical record

Domains reviewed (vitals / orthostatics / labs / ECG):

Referral to (named physician / practice): | Referral date:

Workup ordered: | Release signed (date):

Results due back: | Priority symptoms flagged:

Mental status & co-occurring conditions

Full MSE; depression, anxiety, trauma, and substance use screens completed and filed

Suicide risk

Findings and the reasoning behind the judgment; monitoring plan; elevated risk is the base rate in eating disorders

DSM-5-TR diagnosis & severity

Criteria mapped to endorsed findings; specifier; differential if relevant

Provisional? Y / N | Pending (medical findings / records):

Level-of-care rationale

Recommended level; criteria considered; argued from current status, trajectory, and the medical team's findings

Collaborative plan & communication

Therapy modality and frequency; medical monitoring; nutrition referral; releases; who communicates with whom; review date

Release(s) on file: Y / N | Clinician signature / credentials: | Date signed: