Eating Disorder Diary Card

Name: _____ Week of: _____

Rate the following on a scale of 0 to 10, where 0 = not at all, to 10 = severe or extreme urge. In the "Urges" section, use the same rating scale and write 'Yes' or 'No' if you engaged in the behavior.

Today I felt:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Good/Happy							
Anxious/Worried							
Scared							
Angry/Irritable							
Depressed							
Hopeful							
Empty/Alone							
Hurt							
Physically Bad							
Helpless							
Guilty							
Ashamed							
Today I have an urge to:							
Binge							
Purge							
Weigh myself							
Restrict							
Drink alcohol							
Use drugs							
Use diet pills or diuretics							
Use laxatives							
Abuse caffeine							
Measure myself							
Pinch my fat							
Exercise							
Sleep							
Harm myself							
Isolate							
Avoid hygiene activities							
Total Yes Responses							