For office use - ID:

# Short ARFID Screen – self (SAS-S)

PLEASE ENTER THE INFORMATION REQUESTED IN THIS BOX, THEN ANSWER QUESTIONS 1-7 BELOW. Thank you.

Today's date _____/_____/_____ (day/month/year)

Your age _____/____ (years/months)

Your name _____

Are you: Male ☐ Female ☐ Other ☐_____

| | | Yes definitely | To some extent | Not at all | Unsure | Office use |
|---|---|---|---|---|---|---|
| **1** | Do you have difficulties with eating - involving avoidance or restriction of certain foods or of overall amount eaten – that are NOT explained by a diagnosed medical condition? | | | | | |
| **2** | Are your eating habits related to you thinking that you are too big or too heavy? | | | | | |
| **3** | Over the past 3 months, has your eating led to difficulty maintaining a healthy weight, or if you are still growing, difficulty gaining enough weight to grow as expected? | | | | | |
| **4** | Do you have any nutritional deficiencies or inadequacies as a result of limited eating (e.g. low iron, low vitamin B12, low vitamin C)? | | | | | |
| **5** | Do you depend on tube feeding or nutritional supplements to maintain your nutrition, weight or growth (i.e without these you would have nutritional deficiencies or lose weight)? | | | | | |
| **6** | Does your eating have a negative effect on your day to day life or your ability to participate in a full range of age-appropriate activities? | | | | | |
| **7** | Does your eating have a negative effect on your family/partner relationships or other aspects of your family life (e.g. going out together, on holiday, etc.)? | | | | | |

Further comment:

MC CA ED Maudsley Centre for Child and Adolescent Eating Disorders

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