Modified SCOFF Questionnaire

Patient Name:_____ DOB:_____

This is a brief questionnaire that is looking at your inner attitudes and feelings about food. Please read the questions below and check Yes or No as appropriate.

1) Do you ever make yourself throw up (or use laxatives, water pills or exercise) because you feel uncomfortably full?

   ☐ **Yes** ☐ **No**

2) Do you worry you have lost control over how much you eat?

   ☐ **Yes** ☐ **No**

3) Have you recently lost or gained more than 10-15 pounds in a 3-month period?

   ☐ **Yes** ☐ **No**

4) Do you believe yourself to be fat when others say you are too thin?

   ☐ **Yes** ☐ **No**

5) Do thoughts and fears about food and weight dominate your life?

   ☐ **Yes** ☐ **No**

6) Do you feel bad about yourself because of your weight, shape, or eating habits?

   ☐ **Yes** ☐ **No**