CLIENT SERVICE RECEIPT INVENTORY
Adolescent Eating Disorders Study (Patient Version)

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This instrument is to be used in interview with the patient where s/he does not live in the same household as their parent, guardian, etc.

In this interview we are looking at the practical and financial impact of having an eating disorder. We know these factors are important and would like to know how they effect you.

BACKGROUND INFORMATION

1. Patient name and/or number_____ ☐☐☐

2. Interview identifier *(tick one box)* Baseline ☐ 3 months ☐ 12 months ☐

3. Interviewer's name and/or number_____ ☐☐☐

4. Date of interview ☐☐/☐☐/☐☐
   d d m m y y

5. Did you come to the clinic with anyone else? Yes ☐ No ☐

   If **YES** who was this?_____
   (e.g. mother or aunt)

7. Travelling to the clinic (baseline and 3-month interview only)

	Carer or Significant Other	**Patient***
If you came to the eating disorders clinic with someone else, did you travel together?	YES NO	YES NO
How long does it take you to get to the eating disorders clinic?	Hrs Mins	Hrs Mins
How do you get to the clinic? **CODE:** 1. Walk; 2. Car; 3. Public transport; 4. Taxi; 5. Other.		
How many miles is it from you house (or work) to the clinic?	miles	miles
If you came by taxi/public transport, how much was the fare?	N/A **or** £	N/A **or** £
If you had other expenses (e.g. baby sitter), how much was this?	N/A **or** £	N/A **or** £
Is your travelling time and cost likely to be the same in the future?	YES NO	YES NO
If **NO**, describe briefly how the arrangements might be different…		

* If carer and patient travel together please ensure you do not double count expenses.

HOUSEHOLD CIRCUMSTANCES

8. Please tell me about the type of house you live in. Is it:

(tick one box)

1. Owner occupied ☐
2. Council rented ☐
3. Housing Association ☐
4. Private rented ☐
5. Other (describe ..... ☐

How many bedrooms are there in the house? ☐

9. Who do you usually live with? *(Use home address if you live away during term-time)*

1. Both natural parents ☐
2. Natural mother & her partner ☐
3. Natural father & his partner ☐
4. Relatives or family friends ☐
5. Formal foster care ☐
6. Adoptive parents ☐
7. Residential home ☐
8. Partner ☐
9. Partner & children ☐
10. Other (Describe... ☐

In total, how many people live in the house?

Over 16 years? ☐☐

Under 16 years? ☐☐

IMPACT ON THE PATIENT'S EMPLOYMENT OR EDUCATION

10. Do you have a job? Yes ☐ No ☐

If **YES**

a) What type of job is this? _____

b) How many hours do you usually work each week? ☐☐

c) Have you missed work due to not feeling well in the last 3 months? Yes ☐ No ☐

If **YES**, how many days in the last 3 months? ☐☐

d) Has your eating disorder affected your employment or chances of a career? Yes ☐ No ☐

If **YES**, how has your employment principally been affected? ***(tick one box)***

1. Loss of job ☐
2. Choice of career ☐
3. Absence from work ☐
4. Change in work hours ☐
5. Other (Describe… ☐

11. Are you still in full- or part-time education? Yes ☐ No ☐

If **YES**

a) What type of school or college did you attend last term?

(tick one box)

1. State day school ☐
2. State boarding school ☐
3. Independent day school ☐
4. Independent boarding school ☐
5. Special school (e.g. EBD) ☐
6. College ☐
7. University ☐
8. Other (Describe…. ☐

b) Last term, did you miss any days from school/college due to not feeling well? Yes ☐ No ☐

If **YES**, how many days in the last school term? ☐☐

c) Last term, did you have any extra help with education? ***(tick/complete each box that applies)***

1. Individual tuition at home	Yes ☐	No ☐	No. hours per week	☐☐
2. Individual help in some classes	Yes ☐	No ☐	No. lessons per week	☐☐
3. Lessons in a special unit in school	Yes ☐	No ☐	No. lessons per week	☐☐

d) Last term, did you see any of the following people <u>in school or college</u>?

Professional	**No. of contacts**	**Av. Duration of each contact (mins)**
School nurse		
Educational psychologist		
Educational welfare officer		
Special education needs co-ordinator		
Additional meetings with tutors		
Other (Describe…		

12. Last term, were you excluded or suspended from school or college? Yes ☐ No ☐

No. times excluded permanently ☐☐

No. times suspended (temporary exclusion) ☐☐

IMPACT ON THE PARTNER'S EMPLOYMENT AND INCOME (if s/he accompanied patient)

13. Are you ***(tick one box)***

1. Employed full-time ☐
2. Employed part-time ☐
3. Unemployed ☐
4. A student ☐
5. A housewife/husband ☐
6. Retired ☐
7. Other (Describe… ☐

If unemployed:

a) Month / year last in paid employment ☐☐ / ☐☐ (*m m y y*)

b) Job title of your last paid job_____

c) Did you give up work because of [NAME]'s eating disorder? Yes ☐ No ☐

If employed:

a) What is your job title?_____

b) How many hours do you usually work each week ☐☐

c) How many days have you been absent from work in the last 3 months? ☐☐

d) Of these days absent, how many were due to [NAME]'s eating disorder? ☐☐

e) Has [NAME]'s eating disorder affected your working hours within the last 3 months? Yes ☐ No ☐

If **YES**: How many hours <u>less</u> have you worked per week? ☐☐

f) Please tick the box for each problem related to [NAME]'s eating disorder that effects your working ability.

1. Tired ☐
2. Worried/anxious ☐
3. Feeling down ☐
4. Difficult to concentrate ☐
5. Phone calls about the child ☐
6. Leaving work to collect him/her ☐
7. Other …… ☐

Of these problems you've been having at work, which is the most important? ☐

How often does it effect your working day? ***(tick one box)***

1. Less than once a month ☐
2. Once or twice a month ☐
3. Once or twice a week ☐
4. Once or twice a day ☐

USE OF SERVICES

14. Have you used any hospital in-patient services in the <u>last **3** months</u>?

Admission	Reason for stay	Ward speciality (eg Paediatrics)	No of inpatient days in last 3 months
1			
2			
3			

15. Have you used any other hospital services in the <u>last **3** months</u>?

Services used	Number of attendances due to eating disorder	Number of other attendances
Accident & Emergency or Minor Injuries Unit		
Other out patient (paediatrics dept., children's depart)		
Day Hospital Treatment setting		

16. Have you used any of the following community services in the last 3 months?
Please ensure you exclude services used in school, college or hospital that are recorded above.

Service	Number of contacts at surgery/office	No. visits at home	Av. duration of each contact (min)
Health visitor			
Dentist			
GP/Practice nurse			
Optician			
Child development centre			
Child guidance unit			
Dietician			
Family therapist			
Individual therapy			
Psychiatrist/psychologist			
Other (Describe…			
Social worker			
After school/homework club			
Other (Describe…			
Other (Describe…			
Other (Describe…			
Other (Describe…			

PARTNER'S SERVICES USE (if s/he accompanied patient)

17. Has your partner used any services over the last 3 months as a result of your eating disorder?
(For example, additional visits to GP, social services, psychiatric services, marriage guidance, counselling, self help groups, alternative medicine, advice lines)

Service	Number of contacts at surgery or office	Number of visits at home	Av. duration of each contact (mins)

Thank you for your help