# Eating Disorder Youth Service (EDYS)

# YOUNG PERSONS INFORMATION FORM

***We are grateful if you could complete this prior to your assessment.***

1. Why do you think you need this appointment?

2. What would you like to be different after coming to EDYS?

3. What do you think would help you?

4. Would you like time to talk on your own? YES/NO

Name: Date: