Health and Nutrition Direction

An Individualized Medical Pathway to Weight Management

This questionnaire is designed to give our HAND staff the information we need to help you and your child create new health goals. Please try to answer as honestly and thoroughly as possible. There are no right or wrong answers!

Patient Name: _____ Date of Birth _____ Today's Date: _____

1. Do you think your child has been gaining too much weight lately? Yes No (If no, go to question #4)
2. When did you first notice this? _____
3. Do you associate a life event that led to the weight gain and, if so, what? (start of medication, stress, illness or death in family, etc.) _____
4. Has your child made changes to his or her diet or activity level to work toward a healthy weight? Yes No
5. Did it work? Yes No If no, why not? _____
6. Does your child spend a lot of time thinking about his or her weight? Yes No Don't Know
7. Does your child have a good body image? Yes No Don't Know
8. Have there been any recent stressful life events? (i.e. move, school stressors, divorce, parents remarried, etc.) Yes No If yes, please explain:

   _____

9. Does your child take, or has your child ever taken, any medications for weight (including nutritional supplements)? Yes No *If yes, please fill out the following:*

Name of medication/supplement	*How long taken?*	*Currently taking?*	*Any weight change?*	*Side effects?*

10. Is your child hungry (please circle) All of the time? Most of the time? Some of the time? Never?
11. Does your child eat a large amount of food in short amounts of time (binge eating)? Yes No Don't Know

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12. Does your child ever hide eating from others? No Sometimes Often Don't Know

13. Has your child skipped meals, taken pills, starved, vomited, etc. to try to change weight? Yes No

    If yes, please describe_____

14. Does your child eat for the following reasons?

As a reward	No	Sometimes	Often
Stressed	No	Sometimes	Often
Angry	No	Sometimes	Often
Bored	No	Sometimes	Often
Sad	No	Sometimes	Often
Nervous/Worried	No	Sometimes	Often

15. Please mark the weight status of family members and if they have any of the following:

Family Member	Weight Status (underweight, normal, overweight)	High Cholesterol	Heart Disease	Diabetes	Depression/ Anxiety
Father		Yes No	Yes No	Yes No	Yes No
Mother		Yes No	Yes No	Yes No	Yes No
Sibling 1 age___		Yes No	Yes No	Yes No	Yes No
Sibling 2 age___		Yes No	Yes No	Yes No	Yes No
Sibling 3 age___		Yes No	Yes No	Yes No	Yes No
Sibling 4 age___		Yes No	Yes No	Yes No	Yes No
grandparents		Yes No	Yes No	Yes No	Yes No

16. How many times per week does your child eat fast food (including pizza)? _____times **per week.**

    What does he/she usually order? _____

17. How often does your child drink the following?

Beverage	NEVER	a few times a MONTH	a few times a WEEK	DAILY	MORE than once DAILY
Water					
Milk					
Fruit juice					
Soda (regular)					
Soda (diet)					
Lemonade, punch					
Energy Drinks					
Coffee/Coffee drinks					
Hot Chocolate					

18. What does your child eat on a typical day?

    Breakfast _____

    Snack_____

    Lunch _____

    Snack _____

    Dinner _____

    Snack _____

19. During the school year, how many days/week does your child typically buy school lunch? _____

20. Does your child ever eat meals in front of the T.V.? Yes No If yes, how many times/week? _____

21. How many times per week does your child play outside for at least 30 minutes? _____

22. How many hours, in a typical week, is your child physically active, including gym class, organized physical activities outside of school (i.e. gymnastics, volleyball, dance, karate, etc.) _____

23. How many hours of screen time does your child have per day (not including school work)? (i.e. gaming, movies, texting, social media, T.V., computer, etc.) _____

24. Does your child have a T.V. or computer in his/her room? Yes No

25. Is your child a victim of serious teasing or criticism about weight? Yes No
    If yes, please explain
    _____

26. How many days per month, on average, does your child miss school? _____

    Were any of these days missed because of weight issues (i.e. doctor visits, anxiety about being teased, body image concerns, etc.) Yes No N/A
    If yes, please explain
    _____

27. What are your and your child's goals for participation in the HAND Pathway?

_____

_____

_____

_____

28. Is there anything else not asked on this questionnaire that you would like us to know in order to help your child?

_____

_____

_____

_____

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