Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

WEIGHT MANAGEMENT – INITIAL VISIT QUESTIONNAIRE

Patient and parent(s) should complete this form together

1. How do you feel about your weight?

   _____

2. Are you ready to make a change? *PATIENT*: ☐ Yes ☐ No *PARENT*: ☐ Yes ☐ No
3. Have you tried losing weight before? ☐ Yes ☐ No
   What have you done before? _____
   Was it successful at the time? _____
4. Who lives at home? _____
5. Who prepares meals? (parent, grandparent, as a family) _____
6. On average, how many nights a week do you eat out? (restaurant, fast food, etc) _____
7. On average, how many nights a week do you eat together as a family? _____
8. Do others make comments about your weight? _____
9. How do you spend your free time? _____
10. How much sleep do you get at night? _____
11. What is your biggest weakness with food? (ex: portions, type of food, etc)

    _____

12. Do you have a TV in your room? *PATIENT*: ☐ Yes ☐ No *PARENT*: ☐ Yes ☐ No
13. Do you have a computer in your room? *PATIENT*: ☐ Yes ☐ No *PARENT*: ☐ Yes ☐ No
14. Do you have your own cell phone? *PATIENT*: ☐ Yes ☐ No
15. Do you eat any meals with the TV on? ☐ Yes ☐ No
    If yes, how often? _____

Do you experience any of the following:

Depression	☐ Yes ☐ No	*Weight changes*	☐ Yes ☐ No	*Abdominal pain*	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	*Vision changes*	☐ Yes ☐ No	*Joint pain*	☐ Yes ☐ No
Avoiding school	☐ Yes ☐ No	*Headaches*	☐ Yes ☐ No	*Back pain*	☐ Yes ☐ No
Avoiding social activities	☐ Yes ☐ No	*Snoring*	☐ Yes ☐ No	*Menstrual irregularities*	☐ Yes ☐ No
Excessive urination	☐ Yes ☐ No	*Daytime sleepiness*	☐ Yes ☐ No	*Alcohol/Smoking*	☐ Yes ☐ No
Excessive thirst	☐ Yes ☐ No	*Fatigue*	☐ Yes ☐ No	*Heartburn*	☐ Yes ☐ No