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

WEIGHT MANAGEMENT – FOLLOW UP VISIT QUESTIONNAIRE

Patient and parent(s) should complete this form together

1. Do you get physical activity at least 3 times each week? ______________________________
2. How much non-homework screen time do you have each day? ______________________________
   Screens include TV, computer, video games, cell phone
3. How many servings of fruits and vegetables are you eating each day? ____________________
4. Have you limited treats to 2 servings per day? ______________________________________
   Remember any food/drink not on the Wholesome Foods List is a treat
5. Are you eating regular meals daily? *(breakfast, lunch, and dinner)* ☐ Yes ☐ No
   If not, why? ____
6. How much water are you drinking each day? ______________________________________
7. What food changes have you made based on the Wholesome Foods List? (whole grains, low-fat dairy, etc)
   ____
8. Do you measure portion sizes for snacks & meals? ____________________________________
9. Are you keeping a food diary? ____
10. What changes have you made since our last visit? ____________________________________
    ____

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