Weight Management

QUESTIONNAIRE

Today's date: _____

Patient name: _____

Date of birth: _____

For children 12 years old or younger,

to be completed by mom, dad, or other adult.

Some questions may not apply to very young children.

MEDICAL AND WEIGHT HISTORY

Child's height: Current weight:

Do you think your child has been gaining too much weight?
O no O yes

If yes, when do you think your child began gaining too much weight? _____

Has your child done anything to try to reach and keep a healthy weight? O no O yes *If yes, please list:*

_____

Did it work? O no O yes

Why or why not? _____

Does your child take or has your child taken any medications for weight, including nutrition supplements (vitamins, herbs)?
O no O yes *If yes, please fill out the following:*

Name of medication or supplement:	How long did he/she take the medication or supplement?	Is he/she currently taking the medication or supplement?	List any weight change:	List any side effects (e.g., dizziness, upset stomach):
1.				
2.				

Does your child spend a lot of time thinking about being thin or about ways to lose weight? O no O yes O don't know

Does your child eat large amounts of food in a short time (binge)?
O no O sometimes O often don't know

Does your child ever hide eating from others?
O no O sometimes O often don't know

Has your child skipped meals, taken pills, starved, vomited, etc. to try to change weight? O no O yes *(describe below)*

_____

Does your child eat for the following reasons?

As a reward	O no	O sometimes	O often
Stressed	O no	O sometimes	O often
Angry	O no	O sometimes	O often
Bored	O no	O sometimes	O often
Sad	O no	O sometimes	O often
Nervous/worried	O no	O sometimes	O often

Please mark the weight status of family members and if members of your family have any of the listed health problems:

Family Member	**Weight Status** *(underweight, normal, overweight)*	**High Cholesterol**	**Heart Disease**	**Diabetes**	**Depression/ Anxiety**
Father	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes
Mother	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes
Sibling 1 ____ *age*	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes
Sibling 2 ____ *age*	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes
Sibling 3 ____ *age*	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes
Sibling 4 ____ *age*	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes
Grandparents	O under O normal O over	O no O yes	O no O yes	O no O yes	O no O yes

Additional comments or concerns:

Pat Qst 50113

Intermountain® Healthcare

Today's date: _____ Patient name: _____ Date of birth: _____

BREAKFAST: How many days a week does your child eat breakfast? _____ days **per week**

SNACKS: How many snacks does your child eat each day? _____ snacks **per day**

FAST FOOD: How many times a week does your child eat fast food? _____ times **per week**

FOOD	***How often does your child eat:***	NEVER	a few times a MONTH	a few times a WEEK	DAILY	MORE than once DAILY
FRUIT	Whole fresh fruit such as apples, oranges, bananas, peaches, berries, etc.	○	○	○	○	○
	Canned or frozen fruits	○	○	○	○	○
	Fruit leather, fruit roll-ups (fruit candy)	○	○	○	○	○
VEGETABLES	Dark green vegetables such as broccoli, spinach, kale, dark green lettuce	○	○	○	○	○
	Orange vegetables such as squash, carrots, sweet potatoes	○	○	○	○	○
	Legumes such as navy, pinto, or black beans	○	○	○	○	○
	Starchy vegetables such as potatoes, peas, and corn	○	○	○	○	○
	Other vegetables such as beets, green beans, cauliflower, cabbage, tomatoes	○	○	○	○	○
BEVERAGES	Water	○	○	○	○	○
	Milk	○	○	○	○	○
	Fruit juice	○	○	○	○	○
	Soda pop, regular	○	○	○	○	○
	Soda pop, diet	○	○	○	○	○
	Lemonade, punch, or Kool-aid	○	○	○	○	○
	Flavored water or sports drinks (Gatorade, Powerade)	○	○	○	○	○
	Energy drinks (Red Bull, Full Throttle, Mt. Dew MDX, etc.)	○	○	○	○	○
	Coffee or coffee drinks	○	○	○	○	○
	Hot chocolate	○	○	○	○	○

ACTIVITY

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

Does your child participate in any individual or team sports, dance, or martial arts? ○ no ○ yes _____ *which?*

How many times per week does your child walk to or from school? _____ *times per week*

Are you able to walk to school with your child? ○ no ○ yes

Are there any recreation or community centers close to your home? ○ no ○ yes ○ don't know

Is there a television in your family eating area? ○ no ○ yes

Is there a television in your child's bedroom? ○ no ○ yes

How many hours per day does your child spend in front of a television, video game, or computer screen? _____ *hours*

What time does your child go to bed? _____ *time*

How many hours of sleep does your child get every day (including naps)? _____ *hours*

Does your child snore? ○ no ○ yes

Is your child sleepy during the day? ○ no ○ yes

SUPPORT

Are there any foods you don't let your child eat? ○ no ○ yes *If yes, please list food and reason for not allowing:*

_____

On average, how many meals each week does your family eat together? _____ *meals per week*

How often do people outside the home feed your child (e.g., daycare, school, friend's house)? _____ *snacks and meals per week*

How often does your family participate in activities such as hiking, walking, biking, gardening, swimming, etc. together?
○ never ○ a few times a month ○ several times a week ○ daily

What activities does your family like to do together?

_____

Do you or other family members make comments about your child's weight? ○ never ○ seldom ○ sometimes ○ often

Do peers/friends make comments about your child's weight? ○ never ○ seldom ○ sometimes ○ often

How do you feel about your child's weight? ○ too thin ○ just right ○ too heavy

Do you feel like you have support to help you manage your child's weight? ○ no ○ yes _____ *who/what?*