Weight Management

QUESTIONNAIRE

For children 13 years old or older,
to be completed by the patient.

Today's date: _____

Patient name: _____

Date of birth: _____

MEDICAL AND WEIGHT HISTORY

Current height: Current weight:

Do you think you have been gaining too much weight? ○ no ○ yes

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

Have you done anything to try to reach and keep a healthy weight? ○ no ○ yes *If yes, please list:* _____

Did it work? ○ no ○ yes

Why or why not? _____

Are you taking or have you taken any medications for weight, including nutrition supplements (vitamins, herbs)? ○ no ○ yes *If yes, please fill out the following:*

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

Do you spend a lot of time thinking about being thin or about ways to lose weight? ○ no ○ yes

Do you ever eat large amounts of food in a short time (binge)? ○ no ○ sometimes ○ often

If so, do you feel out of control when you do? ○ no ○ sometimes ○ often

Do you ever eat in secret? ○ no ○ sometimes ○ often

Have you skipped meals, taken pills, starved, vomited, etc. to try to lose weight? ○ no ○ yes *(describe below)*

_____

Do you 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
Other	○ no	○ sometimes	○ 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	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes
Mother	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes
Sibling 1 ____ *age*	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes
Sibling 2 ____ *age*	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes
Sibling 3 ____ *age*	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes
Sibling 4 ____ *age*	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes
Grandparents	○ under ○ normal ○ over	○ no ○ yes	○ no ○ yes	○ no ○ yes	○ no ○ yes

Additional comments or concerns:

Pat Qst 50113

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

BREAKFAST: How many days a week do you eat breakfast? _____ days **per week**

SNACKS: How many snacks do you eat each day? _____ snacks **per day**

FAST FOOD: How many times a week do you eat fast food? _____ times **per week**

FOOD	***How often do you 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 do you play outside for at least 30 minutes? _____ *times per week*

Do you participate in any individual or team sports, dance, or martial arts? ○ no ○ yes _____ *which?*

How many times per week do you walk to or from school? _____ *times per week*

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 bedroom? ○ no ○ yes

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

What time do you go to bed? _____ *time*

How many hours of sleep do you get every day (including naps)? _____ *hours*

Do people tell you that you snore? ○ no ○ yes

Are you sleepy during the day? ○ no ○ yes

SUPPORT

Are there any foods you are not allowed to eat? ○ no ○ yes *If yes, please list food and reason:*

_____

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

How often do you participate in activities (such as hiking, biking, swimming, dancing, etc.) with your friends or family?

○ never ○ a few times a month ○ several times a week ○ daily

What activities does your family like to do together?

_____

Do your parents or other family members make comments about your weight? ○ never ○ seldom ○ sometimes ○ often

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

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

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

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