Healthy Weight Assessment/Plan

Please complete blue sections only (A, B, C and D).

Patient / Parent: Complete these sections only

A. ASSESSING HABITS

1. How many servings of **FRUITS OR VEGETABLES** does you child eat **a day**? _____
2. How many times **a week** does your child **EAT DINNER AT THE TABLE with the FAMILY**? _____
3. How many times **a week** does your child eat **BREAKFAST**? _____
4. How many times **a week** does your child **EAT TAKEOUT or FAST FOOD**? _____
5. How many **hours a day** does your child **watch TV**, or sit and play **video games**? _____
6. Does your child have a **TV IN THE ROOM** where he/she sleeps? Yes No
7. On most days, **how many minutes** does your child spend in ***ACTIVE*** **PLAY**? *(fast breathing, sweating)* _____
8. How many 8 ounce servings of the following does your child **DRINK** a day? *(An 8 ounce serving is the size of one cup)*

100% Juice _____ Fruit/Sports Drink _____ Soda/punch _____

Whole Milk _____ Fat Free/Low Fat Milk _____ Water _____

B. SETTING A GOAL / REVIEWING IDENTIFIED GOAL

Are there goals that you are ready to try?

5 ☐ Eat at least 5 servings of fruits/vegetables a day

2 ☐ Limit screen time *(especially TV)*

1 ☐ Get at least 60 minutes of physical activity every day

0 ☐ Avoid sugar-sweetened drinks *(soda, sports drinks, punch, etc)*

☐ Other _____

_____

_____

_____

C. PARENT / SCHOOL INFORMATION

Parent/Guardian Name

(Print the name of the parent/guardian to be contacted for follow-up)

Parent Phone Number_____ Child's School_____

D. ACHIEVING MY GOAL

1. How important is it to me to make this change? *(circle a number)*

0	1	2	3	4	5	6	7	8	9	10

Not at all important *Extremely important*

2. What might make it hard to achieve this goal (what are the barriers)?

_____

_____

3. Information or support I might need in accomplishing this goal:

_____

E. TREATMENT PLAN

_____

_____

_____

F. COMMITMENT

I agree to this plan of action and will review the plan and progress _____ *(time frame)*

X_____ *(Patient / Parent/Guardian Signature)* _____(Date)

Weight _____lbs Height _____

BMI _____ ____

Child Name / DOB _____

AFFIX LABEL HERE

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