Health and Nutrition Direction

An Individualized Medical Pathway to Weight Management

This questionnaire is designed to give our HAND staff the information we need to help you create new health goals. Please try to answer as honestly and thoroughly as possible. There are no right or wrong answers!

Patient Name: _____ Date of Birth _____ Today's Date: _____

1. Do you think you have been gaining too much weight lately? Yes No (If no, go to question #4)
2. When did you first notice this? _____
3. Do you associate a life event that led to the weight gain and, if so, what? (start of medication, stress, illness or death in family, etc.) _____
4. Have you made any changes to your diet or activity level to work toward a healthy weight? Yes No
5. Did it work? Yes No If no, why not? _____
6. Do you spend a lot of time thinking about your weight? Yes No Don't Know
7. Do you have a good body image (feel good about your body)? Yes No Don't Know
8. Have there been any recent stressful life events? (i.e. move, school stressors, divorce, parents remarried, etc.) Yes No If yes, please explain:

   _____

9. Do you take, or have you ever taken, any medications for weight (including nutritional supplements)? Yes No
   If yes, please fill out the following:

Name of medication/supplement	*How long taken?*	*Currently taking?*	*Any weight change?*	*Side effects?*

10. Are you hungry (please circle) All of the time? Most of the time? Some of the time? Never?
11. Do you eat a large amount of food in short amounts of time (binge eating)? Yes No Don't Know

12. Do you ever hide eating from others? No Sometimes Often Don't Know

13. Have you skipped meals, taken pills, starved, vomited, etc. to try to change weight? Yes No

    If yes, please describe_____

14. 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

15. Please mark the weight status of family members and if they have any of the following:

Family Member	Weight Status (underweight, normal, overweight)	High Cholesterol	Heart Disease	Diabetes	Depression/ Anxiety
Father		Yes No	Yes No	Yes No	Yes No
Mother		Yes No	Yes No	Yes No	Yes No
Sibling 1 age___		Yes No	Yes No	Yes No	Yes No
Sibling 2 age___		Yes No	Yes No	Yes No	Yes No
Sibling 3 age___		Yes No	Yes No	Yes No	Yes No
Sibling 4 age___		Yes No	Yes No	Yes No	Yes No
grandparents		Yes No	Yes No	Yes No	Yes No

16. How many times per week do you eat fast food (including pizza)? _____times **per week.**

    What do you usually order? _____

17. How often do you drink the following?

Beverage	NEVER	a few times a MONTH	a few times a WEEK	DAILY	MORE than once DAILY
Water					
Milk					
Fruit juice					
Soda (regular)					
Soda (diet)					
Lemonade, punch					
Energy Drinks					
Coffee/Coffee drinks					
Hot Chocolate					

18. What do you eat on a typical day?

    Breakfast _____

    Snack_____

    Lunch _____

    Snack _____

    Dinner _____

    Snack _____

19. During the school year, how many days/week do you typically buy school lunch? _____

20. Do you ever eat meals in front of the T.V.? Yes No If yes, how many times/week? _____

21. How many times per week are you active outside for at least 30 minutes? _____

22. How many hours, in a typical week, are you physically active, including gym class, organized physical activities outside of school (i.e. gymnastics, volleyball, dance, karate, etc.) _____

23. How many hours of screen time do you have per day (not including school work)? (i.e. gaming, movies, texting, social media, T.V., computer, etc.) _____

24. Do you have a T.V. or computer in your room? Yes No

25. Are you a victim of serious teasing or criticism about weight? Yes No
    If yes, please explain
    _____

26. How many days per month, on average, do you miss school? _____

    Were any of these days missed because of weight issues (i.e. doctor visits, anxiety about being teased, body image concerns, etc.) Yes No N/A
    If yes, please explain
    _____

27. What are your goals for participation in the HAND Pathway?

_____

_____

_____

_____

28. Is there anything else, not asked on this questionnaire, that you would like us to know in order to help you?

_____

_____

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_____

Endocrine Kids is lending a HAND