Addendum Assessment & Counseling Form_Pediatric Overweight

Name _____ DOB _____ Record # _____

Assessment

Date	BMI	BMI:Age Percentile	BP	BP:Age Percentile	Hrs PA*	Hrs Sedentary	FL Quiz Score**	Pledge Signed?

*Structured and leisure physical activity per week
**Family Lifestyle Quiz

Date	Total Cholesterol	LDL	BS	Liver enzymes	Thyroid Function	Serum/urinary Cortisol

Family history of obesity	Y N	Depression	Y N
Number of months breastfed	_____ Mos	Altered self esteem	Y N
# of previous weight loss attempts	_____	Altered body image	Y N
Does pt/caregiver see overweight as a problem	Y N	Striae	Y N
Oligomenorrhea	Y N NA	Hirsutism	Y N
Amenorrhea	Y N NA	Acanthosis nigricans	Y N
Snoring	Y N	Hepatomegaly	Y N
Breathing difficulties	Y N	Hip or knee pain	Y N
Daytime somnolence	Y N	Leg bowing	Y N

Perceived causes of weight gain _____

_____

Family Counseling

	Date		Date		Date
Complications of overweight	_____	Empty calories	_____	Eating breakfast	_____
Parent as role models	_____	Healthy drinks	_____	Dining out	_____
Calcium intake	_____	Healthy snack foods	_____	Limiting fast foods	_____
Fruits and vegetables	_____	Portion size	_____		_____
Physical activity	_____	Limit screen time (TV/computer/games)			_____