Southern Pediatric Clinic, LLC
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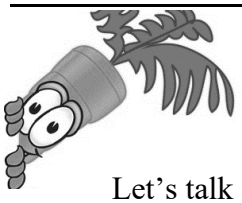
Patient Name: _____Date of Birth_____ Date: _____

BMI Management Clinic Evaluation/Progress Form (4yrs & older)



I… Let's talk about your **NUTRITION**…	☐ Drink more than 6-8 oz of sweet beverage a day ☐ Do not enjoy drinking water and 1% or 2% milk ☐ Eat less than 5 servings of fruits and vegetables a day ☐ Do not eat breakfast regularly ☐ Eat large portion sizes/often gets seconds ☐ Eat more than 2 snacks a day ☐ Eat out 3 or more times a week	Notes:
I… And your **PHYSICAL & SOCIAL ACTIVITY**…	☐ Spend more than 1-2 hours a day watching TV or playing video games ☐ Do not spend 1 hour a day doing physical activity ☐ Sleep fewer than 8-9 hours at night ☐ Feel stressed a lot of the time	Notes:
Since my last visit, **my family** is making these **DIETARY CHANGES**…	☐ Limiting sugar sweetened beverages ☐ Increasing intake of fruits/vegetables ☐ Eating breakfast daily ☐ Limiting eating out/fast food ☐ Limiting portion sizes	Notes:
Since my last visit, **my family** is making these **ACTIVITY & SOCIAL CHANGES** to**…**	☐ Limit TV/video game time to 2 hours per day ☐ Physical activity for 1 hour per day ☐ Sleep at least 8 hours at night ☐ Decrease stress in my life	Notes:

FOR THOSE AGES 11 YRS & OLDER

● Some people don't want to talk about their weight at all, where some people don't mind. How do you feel about this?
☐ I don't want to talk about my weight ☐ I do want to talk about my weight

● Is your current weight affecting your life right now? ☐ No ☐ Yes

● Would you like your health to be different? ☐ No ☐ Yes

● How **ready** do you feel to change your eating patterns and/or lifestyle behaviors?	0 (not ready)	5 (kind of ready)	10 (very ready)
● How **interested** are you in learning how to change your eating patterns and/or lifestyle behaviors?	0 (not interested)	5 (some interested)	10 (very interested)
● Do you **think** about changing your eating patterns and/or lifestyle behaviors?	0 (never)	5 (sometimes)	10 (often)

● Is there anything that would make you feel more confident about making these changes? ☐ No ☐ Yes
If yes, what?

● What things stand in the way of you taking the first step to these changes?

● If you decide to change, what might your options be?