



2018 Clinch Avenue
Knoxville, Tennessee 37916

Patient Questionnaire

Patient Information

Patient name (Last, First, Middle): _____

Patient date of birth: ____/____/____ Patient sex: Male Female

Patient gender: Male Female Non-binary

Caregiver name (Last, First): _____

Relationship to patient: _____

Address: _____

Contact email: _____ Contact phone: _____

Primary language: _____ Interpreter needed: Yes No

Program goals:

| | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------|------------|---|---|----------|---|---|---|------|---|----|
| On a scale of 1 to 10, how concerned are you about your child's weight today? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Not at all | | | Somewhat | | | | Very | | |
| On a scale of 1 to 10, how ready are you to make changes in your child and family's eating and activity behaviors? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Not at all | | | Somewhat | | | | Very | | |

What is your overall goal for attending Healthy Ways Clinic?

Parent goal(s): _____

Patient (if >7 years old) goal(s): _____

Has patient tried losing weight before?

- If yes, what have you tried?
- Did it help?

| Schedule/Routine | Weekdays | Weekends |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Does patient have a bedtime? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many hours of sleep on a typical night? | | |
| What is patient's usual sleep schedule? | Bedtime: Wake Time: | Bedtime: Wake Time: |
| Which meals does patient usually eat? | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner |
| Where does patient usually eat breakfast? | <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> N/A | <input type="checkbox"/> Home <input type="checkbox"/> Out <input type="checkbox"/> N/A |
| What is a typical lunch? | <input type="checkbox"/> School meal <input type="checkbox"/> Pack <input type="checkbox"/> N/A | <input type="checkbox"/> Home <input type="checkbox"/> Out <input type="checkbox"/> N/A |
| When does patient usually eat snacks? (circle all that apply) | <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Bedtime <input type="checkbox"/> Overnight | <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Bedtime <input type="checkbox"/> Overnight |
| Does classroom/childcare have snack time? | <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon | |
| What does patient do with free time? (check all that apply) | <input type="checkbox"/> Play outside <input type="checkbox"/> Engage in sports <input type="checkbox"/> Play video games <input type="checkbox"/> Watch TV/internet <input type="checkbox"/> Complete chores <input type="checkbox"/> Do homework/read <input type="checkbox"/> Attend aftercare <input type="checkbox"/> Work | <input type="checkbox"/> Play outside <input type="checkbox"/> Engage in sports <input type="checkbox"/> Play video games <input type="checkbox"/> Watch TV/internet <input type="checkbox"/> Complete chores <input type="checkbox"/> Do homework/read <input type="checkbox"/> Attend aftercare <input type="checkbox"/> Work |

| Environmental factors | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Who does patient live with? | Home 1: |
| • Is custody shared? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Home 2: |
| Does patient attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No | Grade: In-person Virtual Homeschool |
| Does patient attend childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No | # days per week: _____ # hours per day: _____ |
| Does patient attend an aftercare program? <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ If yes, where? |
| Does patient have difficulty with sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ If yes, describe: |
| At what age were you first concerned about patient's weight? | |
| Does patient's weight affect how s/he feels about him/herself? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure | |
| Is patient being teased because of his/her weight? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure | |
| Is anyone else in the family trying to lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure | |
| • If yes, how? | |
| Does the family eat meals together? <input type="checkbox"/> Yes <input type="checkbox"/> No | Where? |
| Where does patient eat most often when home? | |
| Are any screens (TV, phones, tablets) usually allowed during meals? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| How many hours of screen time does patient get each day (not including school work)? | |
| <input type="checkbox"/> Eating too much | <input type="checkbox"/> Other medical problem |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Too much time watching TV |
| <input type="checkbox"/> Eating the wrong kinds of food | <input type="checkbox"/> Life event (change in school, change in family) |
| <input type="checkbox"/> Gland or hormone problem | <input type="checkbox"/> Too much time playing video games |
| <input type="checkbox"/> Not enough exercise | <input type="checkbox"/> Too much time on phone/internet |

| Diet and nutrition | | | | |
|---------------------------------------------------------------------|---------------------|--------------------|--------------------|-------------------------|
| Describe patient's appetite. | Excellent | Good | Variable | Picky |
| Does patient eat second servings at meals or snacks? | Never | Sometimes | Often | Always |
| How often does patient report hunger? | Never | Sometimes | Often | Always |
| Does patient snack when bored? | Never | Sometimes | Often | Always |
| How often does your family eat out? | 1-2 times per month | 1-2 times per week | 3-5 times per week | 6-7 times per week |
| Where do you eat out most often? | | | | |
| Indicate frequency of intake for the following foods and beverages. | | | | |
| • Sugar sweetened beverages (soda, sweet tea, sport drink, etc) | 0-3 times per month | 1-3 times per week | 3-5 times per week | 1 or more times per day |
| • Fruit juice | 0-3 times per month | 1-3 times per week | 3-5 times per week | 1 or more times per day |
| • Fruit | 0-3 times per month | 1-3 times per week | 3-5 times per week | 1 or more times per day |
| • Vegetables | 0-3 times per month | 1-3 times per week | 3-5 times per week | 1 or more times per day |
| • Milk | 0-3 times per month | 1-3 times per week | 3-5 times per week | 1 or more times per day |
| List usual foods and beverages: | | | | |
| • Breakfast | | | | |
| • Lunch | | | | |
| • Dinner | | | | |
| • Snacks | | | | |
| | | | | |

| Physical Activity | | | |
|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------|----------------------------------------------|
| How concerned are you about how your patient's weight affects the following | | | |
| a) Current Health Issues Very Much | <input type="checkbox"/> Somewhat | <input type="checkbox"/> A little | <input type="checkbox"/> Not at all |
| b) Future Health Issues | <input type="checkbox"/> Somewhat | <input type="checkbox"/> A little | <input type="checkbox"/> Not at all |
| c) Ability to participate in play or physical activity | <input type="checkbox"/> Somewhat | <input type="checkbox"/> A little | <input type="checkbox"/> Not at all |
| d) Ability to perform activities of daily living (getting in and out of bed, dressing, etc) | <input type="checkbox"/> Somewhat | <input type="checkbox"/> A little | <input type="checkbox"/> Not at all |
| Home Environment: | | | |
| a) Do you have any stairs to enter the home? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Do you have any stairs inside your home? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Does patient have trouble navigating your home environment? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has anything limited your child's physical activity or mobility in the last 2 years? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does patient experience any of the following symptoms during or after exercise? | <input type="checkbox"/> Soreness | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Headaches |
| | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of breath |
| | <input type="checkbox"/> Joint pain | | |
| Has patient ever had physical therapy or occupational therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| If yes, list: | | | |
| Is patient able to keep up with siblings or peers/classmates? | | | |
| How would you rate patient's physical activity levels? | <input type="checkbox"/> Sedentary/Inactive | | |
| | <input type="checkbox"/> Lightly Active (1-2 days per week) | | |
| | <input type="checkbox"/> Active (3-4 days per week) | | |
| | <input type="checkbox"/> Very Active (5-7 days per week) | | |
| Does patient have PE this year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how often? |
| Does patient participate in any sports at school or in the community? Please list activities: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Does patient participate in physical activity at home or in the community? Please list activities: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |