Strong4Life℠ Pediatric Weight Management Nutrition Assessment Tool (for ages 3 to 18)

Children's℠ Healthcare of Atlanta

Visit date: MM|DD|YYYY Start time: _____ End time: _____ Visit #: _____

Patient name: _____ DOB: MM|DD|YYYY Age: _____

Parent/caregiver present: _____

Medical Dx: _____ Dx codes: _____

ASSESSMENT

Wt: _____ Ht: _____ IBW: _____ BMI: _____ BMI %:

Body fat % (If applicable): _____ Waist circumference: _____

Goal(s) set at previous visit? (If applicable) _____

Goal(s) met? (If applicable) _____

Patient/caregiver reports: _____

Patient medical and weight history: _____

Pertinent family medical history: _____

Patient lab results: _____

Medications/vitamin/mineral supplements: _____

Food allergies/intolerances: _____

Daily energy needs: _____ Kcal _____ grams protein _____ grams fat _____ grams carb _____ grams fiber

Reviewed intake log (if applicable): _____

Dietary History

Typical breakfast: Time: Location:	**Typical a.m. snack:** Time: Location:	**Typical lunch:** Time: Location:	**Typical p.m. snack:** Time: Location:	**Typical dinner:** Time: Location:	**Typical HS snack:** Time: Location:

Child/teen eating behaviors: (Check all that apply)

- ☐ Breakfast/lunch/snacks at school (_____ x/wk)
- ☐ Skips meals (B/L/D) (_____ x/wk)
- ☐ Water intake (_____ oz./day)
- ☐ Juice/sweet drinks (_____ x/day)
- ☐ Meals/snacks away from the table
- ☐ Picky eating tendencies
- ☐ Preoccupation with food
- ☐ Diet-focused mentality
- ☐ Eats beyond fullness
- ☐ Likes fruits/vegetables
- ☐ Dislikes fruits/vegetables
- ☐ Hides food
- ☐ Other: _____
- ☐ Other: _____

Comments: _____

Parent/caregiver feeding behaviors: (Check all that apply)

- ☐ Eats together as a family
- ☐ Keeps sweets/fatty foods in the house
- ☐ Excessive fast food/convenience foods
- ☐ Lack of role modeling
- ☐ Forces food/beverage intake
- ☐ Restricts food/beverage intake
- ☐ Distractions while eating
- ☐ Inconsistent meal planning
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Comments: _____

Physical activity/sedentary behaviors: (Check all that apply)

- ☐ Sports/structured activity: Type(s): _____ (_____ days/wk) (_____ hrs./day)
- ☐ PE at school (_____ days/wk)
- ☐ Watches TV (_____ hrs./day)
- ☐ Uses computer/tablet (_____ hrs./day)
- ☐ Uses cell phone (_____ hrs./day)
- ☐ Plays video games (_____ hrs./day)
- ☐ Sleeps at night (_____ hrs./night)

Comments: _____

NUTRITION DIAGNOSIS/PES STATEMENT (Behavior-focused)

1) _____ related to _____ as evidenced by _____

2) _____ related to _____ as evidenced by _____

Comments: _____

INTERVENTION

Nutrition/counseling topics covered: (Check all that apply)

- ☐ Water intake
- ☐ Sugar demo/limit sugary drinks
- ☐ Ps and Cs
- ☐ Meal planning
- ☐ Limit screen time/sedentary behavior
- ☐ Be more active
- ☐ Fast food/convenience foods
- ☐ Food groups (fruits/veggies/protein/grains/dairy)
- ☐ Label reading
- ☐ Plate method/portions sizes
- ☐ Healthy eating on a budget
- ☐ Assigned intake log (photo/written/online/app)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Comments: _____

Education materials/resources provided: (Check all that apply)

- ☐ Healthy habits for kids
- ☐ Ps and Cs
- ☐ Drink more water
- ☐ Tips for eating out
- ☐ Physical activity
- ☐ Exercise talk test
- ☐ The grocery store
- ☐ Food/drink/physical activity log
- ☐ Strong4Life.com
- ☐ Goal sheet
- ☐ Other: _____
- ☐ Other: _____

Comments: _____

SMART Goals: Specific, Measurable, Achievable, Realistic and Timely

1) _____

2) _____

MONITORING & EVALUATION

Comments: _____

RDN signature: _____ Date: MM|DD|YYYY

Next visit date/time: MM|DD|YYYY Topic for next visit: _____