**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Record# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Get Healthy Action Plan Initial Assessment**  **Please circle the best answer:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Can we talk about your child’s weight today? | Yes | | Don’t know | | No | | |
| Are any family members overweight? | Yes | | Don’t know | | No | | |
| Do any family members have diabetes? | Yes | | Don’t know | | No | | |
| Do any family members have high blood pressure? | Yes | | Don’t know | | No | | |
| Have any family members died from a heart attack before age 55? | Yes | | Don’t know | | No | | |
| How many times a week does your child eat out  (fast food, restaurants, and cafeteria)? | 4+ | | 1-3 | | 0 | | |
| How many days a week does your child eat breakfast? | 0-1 | | 2-5 | | 6+ | | |
| How many meals per week does your family eat together? | 0-1 | | 2-4 | | 5+ | | |
| How many ½ cups (4 oz.) of fruits does your child eat each day? | 0 | 1 | 2 | 3 | 4 | 5+ | |
| How many ½ cups (4 oz.) of vegetables does your child eat each day? | 0 | 1 | 2 | 3 | 4 | 5+ | |
| How many sweet or salty snacks does your child eat each day? (cookies, candy, chips, crackers, etc.) | 5+ | 4 | 3 | 2 | 1 | 0 | |
| How many sugary drinks does your child drink per day? (sodas, Gatorade, Vitamin Water, energy drinks, Hi-C) | 2+ | | 1 | | 0 | | |
| How many juices does your child drink per day? | 2+ | | 1 | | 0 | | |
| If your child drinks milk, what kind of milk does he/she drink? | choco-late | whole | nonfat | 1% | 2% | | none |
| How many days per week is your child physically active for 60 minutes or more? (not including PE classes at school) | 0 | 1 | 2 | 3 | 4 | 5+ | |
| How many hours per day does your child watch TV, use the computer/phone/ tablet, or play video games? | 5+ | 4 | 3 | 2 | 1 | 0 | |
| How many hours of sleep does your child get every night? | <6 | 7 | 8 | 9 | 10 | 11+ | |
| On a scale of 0 – 5, how willing are you and your family to make healthy changes (0 = not at all willing, 5 = extremely willing) | 0 | 1 | 2 | 3 | 4 | 5 | |
| On a scale of 0 – 5, how confident are you that you can succeed in making healthy changes (0 = not at all confident, 5 = extremely confident) | 0 | 1 | 2 | 3 | 4 | 5 | |

**Are there any healthy changes you want to start with? Yes No Don’t know**

**If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**