

Wayzata Children's Clinic Operation Get FIT Pre-Program Questionnaire - PARENT



We are very excited that you are interested in becoming involved in Operation Get FIT. We hope you will find it helpful in promoting your child's health and fitness. Please take a few moments to complete these pages. It will allow us to better help your child with his or her personal goals. Welcome to Operation Get FIT!

Patient's Name: _____ Date of Birth: _____

Name of person completing this form: _____

Date form completed: _____

1. What are your goals for your child during Operation Get FIT?
2. What two words would you use to describe your child's health?
3. What things do you think will help your child meet his / her personal health goals?
4. What things do you think will make it hard to meet your child's health goals?
5. Has your child ever had any of the following (check all that apply)?

- | | |
|--|--|
| <input type="checkbox"/> Low energy / fatigue | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Pain in joints / limp |
| <input type="checkbox"/> Wheezing / asthma | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Frequently sad or depressed | <input type="checkbox"/> Restless sleep / sleep apnea |
| <input type="checkbox"/> Short of breath with light exercise | <input type="checkbox"/> Menstrual irregularity (girls only) |

6. Has anyone in your family had any of the following (check all that apply)?

Which relative(s) had this?

- | | | |
|--------------------------|----------------------|-------|
| <input type="checkbox"/> | Diabetes | _____ |
| <input type="checkbox"/> | High blood pressure | _____ |
| <input type="checkbox"/> | High cholesterol | _____ |
| <input type="checkbox"/> | Heart disease | _____ |
| <input type="checkbox"/> | Stroke | _____ |
| <input type="checkbox"/> | Obesity / overweight | _____ |
| <input type="checkbox"/> | Depression | _____ |

7. Check the box next to the items that are true for your child. (Check all that apply).

- He/she eats 5 or more fruits and vegetables every day.
- He/she eats breakfast every day.
- He/she watches TV, plays video games, or works or plays on the computer for less than 2 hours each day.
- He/she participates in sports, dance, or other physical activity 3 or more times each week.
- Our family eats dinner together at the table at least once per week.
- He/she drinks skim or 1% milk more often than other types of milk (2%, whole, chocolate).
- He/she eats whole grain breads instead of white bread.
- He/she has a TV in his/her bedroom.
- He/she frequently eats while watching TV.
- He/she drinks soda, juice, sports drinks, or other sugar sweetened drinks at least once per day.
- He/she eats fast food or take out food more than once per week.

8. We are considering offering group sessions for patients in the Operation Get FIT program with topics such as The Medical Complications of Obesity, Nutritionist Speaker, Exercise Specialist, Chef, and Patient Group Discussions.

Would you and your child be interested in participating in these sessions if offered?

- Yes No

Thank you very much for answering these questions. We are excited to work with your family and help your child meet his/her Operation Get FIT goals.