

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



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 health and fitness. Please take a few moments to complete these pages. It will allow us to better help you with your personal goals. Welcome to Operation Get FIT!

Your Name: _____

Date of Birth: _____

Date Form Completed: _____

1. What are your personal health goals for Operation Get FIT?
2. What two words would you use to describe your health?
3. What two words would you use to describe your body?
4. What things do you think will help you meet your health goals?
5. What things do you think will make it hard to meet your health goals?
6. What fruit or vegetable would you eat every day if you could?
7. What sports or physical activities do you love to do?
8. How would you describe your energy level (circle a number)?

Very low

1

2

3

4

Very high

5

9. How would you describe your mood (circle a number)?

Usually sad

1

2

3

4

Usually happy

5

10. Have you 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) |

11. 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 | _____ |

12. Check the box next to the items that are true for you. (Check all that apply).

- I eat 5 or more fruits and vegetables every day.
- I eat breakfast every day.
- I watch TV, play video games, or work or play on the computer for less than 2 hours each day.
- I participate in sports, dance, or other physical activity 3 or more times each week.
- My family eats dinner together at the table at least once per week.
- I drink skim or 1% milk more often than other types of milk (2%, whole, chocolate).
- I eat whole grain breads instead of white bread.
- I have a TV in my bedroom.
- I frequently eat while watching TV.
- I drink soda, juice, sports drinks, or other sugar sweetened drinks at least once per day.
- I eat fast food or take out food more than once per week.

13. 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 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 you and help you meet your Operation Get FIT goals.