CHILD'S NAME:______________________________ **Date of Birth:**____________ **Sex:** ☐ M ☐ F **Date of Visit:** ______________

ID # __________________ Enrolled in POC Program? Y / N

VITAL SIGNS (BASELINES)

HT ______ in/cm ______% **WT** ______ lb/kg ______% **BMI** ______ kg/m^2 **BMI%** ______

BP ______ / ______ mmHg **BP** ______ / ______ mmHg **Average BP:** ______ / ______ mmHg **BP %ile:**_______

BP Category: ☐ normal ☐ pre-hypertensive ☐ hypertensive

DIAGNOSES AND CO-MORBIDITIES

- ☐ No existing
- ☐ Abnormal lipids
- ☐ Abnormal weight gain
- ☐ Acanthosis nigricans
- ☐ Asthma
- ☐ Disordered Eating *(binge, food seeking, etc)*
- ☐ GERD
- ☐ Elevated blood pressure; hypertension (not diagnosed)
- ☐ Hypertension
- ☐ Mental Illness (e.g. Depression, Anxiety)
- ☐ Elevated liver enzymes
- ☐ NASLD or NASH
- ☐ Metabolic syndrome
- ☐ Orthopedic issues/ joints/ bone problems
- ☐ Overweight
- ☐ Obesity
- ☐ Abnormal menses
- ☐ Polycystic ovarian syndrome
- ☐ Pre- Diabetes
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Other ____________________________

Do you need to order labs? ☐ Yes ☐ No

If yes, which ones were ordered?

- ☐ Fasting lipid profile
- ☐ Fasting glucose
- ☐ AST/ALT
- ☐ BUN
- ☐ Cr

BEHAVIORAL ASSESSMENT - INITIAL VISIT

Did you explain and raise awareness of the health risks associated with excess weight? ☐ Yes ☐ No

Did you discuss any ambivalence to change that the family may be feeling? ☐ Yes ☐ No

Did you help the family discuss the pros and cons of changing their behavior? ☐ Yes ☐ No

Is the child/family ready to make changes? ☐ Yes ☐ No

Was a target behavior (s) identified (only for those who are engaged and ready)? ☐ Yes ☐ No

If so, what:

- ☐ Increase physical activity
- ☐ Decrease screen time
- ☐ Eat breakfast daily
- ☐ Eat more family meals
- ☐ Eat less fast food
- ☐ Eat more fruits & vegetables
- ☐ Reduce sugary beverages
- ☐ Regulate portion sizes
- ☐ Structure eating patterns
- ☐ Structure sleeping patterns
- ☐ Change dairy habits

Plan: ____

____

____

____

____

What specific goal (s) was/were set? ____

____

____

____

____

____

Time spent counseling ____________ minutes

Note handouts given to family on next sheet.

CHILD'S NAME:________________________________ **Date of Birth:**____________ **Sex:** ☐ M ☐ F **Date of Visit:** _______________

ID # ___________________ Enrolled in POC Program? Y / N

Please note the handouts given to the family at each Pound of Cure office visit. Record the date of the follow up visit.

Initial Visit	1st Follow Up Visit	2nd Follow Up Visit	3rd Follow Up Visit	4th Follow Up Visit	5th Follow Up Visit
☐ None	__________	__________	__________	__________	__________
☐ Keeping it Balanced	__________	__________	__________	__________	__________
☐ 3 Day Food Diary	__________	__________	__________	__________	__________
☐ Go, Slow, Whoa! Foods	__________	__________	__________	__________	__________
☐ Guide to Good Eating	__________	__________	__________	__________	__________
☐ Proper Portions	__________	__________	__________	__________	__________
☐ Snack Foods	__________	__________	__________	__________	__________
☐ Sugary Beverages	__________	__________	__________	__________	__________
☐ Juice	__________	__________	__________	__________	__________
☐ The Milk Group	__________	__________	__________	__________	__________
☐ Physical Activity	__________	__________	__________	__________	__________
☐ Screen Time	__________	__________	__________	__________	__________
☐ Breakfast	__________	__________	__________	__________	__________
☐ Family Meals	__________	__________	__________	__________	__________
☐ Eating Away from Home	__________	__________	__________	__________	__________
☐ Sleep	__________	__________	__________	__________	__________
☐ Fruits & Veggies	__________	__________	__________	__________	__________
☐ Nutrition Facts Label	__________	__________	__________	__________	__________
☐ Shopping Guide	__________	__________	__________	__________	__________
☐ Eating on a Budget	__________	__________	__________	__________	__________
☐ Other Handouts	__________	__________	__________	__________	__________

CHILD'S NAME:_______________________________ **Date of Birth:**____________ **Sex:** ☐ M ☐ F **Date of Visit:** ______________

ID # __________________ Enrolled in POC Program? Y / N

VITAL SIGNS (1st Follow Up Visit)

HT ______ in/cm **WT** ______ lb/kg **Change in WT** ______ lb/kg **BMI** ______ kg/m² **BMI%** ______

BP ______ / ______ mmHg **BP** ______ / ______ mmHg **Average BP:** ______ / ______ mmHg **BP %ile:**_______

BP Category: ☐ normal ☐ pre-hypertensive ☐ hypertensive

DIAGNOSES AND CO-MORBIDITIES

- ☐ No existing
- ☐ Abnormal lipids
- ☐ Abnormal weight gain
- ☐ Acanthosis nigricans
- ☐ Asthma
- ☐ Disordered Eating *(binge, food seeking, etc)*
- ☐ GERD
- ☐ Elevated blood pressure; hypertension (not diagnosed)
- ☐ Hypertension
- ☐ Mental Illness (e.g. Depression, Anxiety)
- ☐ Elevated liver enzymes
- ☐ NASLD or NASH
- ☐ Metabolic syndrome
- ☐ Orthopedic issues/ joints/ bone problems
- ☐ Overweight
- ☐ Obesity
- ☐ Abnormal menses
- ☐ Polycystic ovarian syndrome
- ☐ Pre- Diabetes
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Other ___________________________

BEHAVIORAL ASSESSMENT - 1st Follow up Visit

Did the family attempt the goal set during the initial visit? ☐Yes ☐No **Was it a successful attempt?** ☐Yes ☐No

Were any tracking forms returned? ☐ Yes ☐ No Which one? ___________________________

Relevant Findings: ____

____

Nutritional Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Was a 3-day food diary returned? ☐ Yes ☐ No Relevant Findings: __________________________

____

Comments: ____

____

Activity Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Family/Patient Concerns. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Is the child/family ready to make an additional change(s)? ☐ Yes ☐ No

Was a target behavior (s) identified (only for those who are engaged and ready)? ☐ Yes ☐ No

If so, what:

- ☐ Increase physical activity
- ☐ Decrease screen time
- ☐ Eat breakfast daily
- ☐ Eat more family meals
- ☐ Eat less fast food
- ☐ Eat more fruits & vegetables
- ☐ Reduce sugary beverages
- ☐ Regulate portion sizes
- ☐ Structure eating patterns
- ☐ Structure sleeping patterns
- ☐ Change dairy habits

What handouts were the family given? Note in the initial visit form.

What specific goal (s) was/were set? ____

____

____

____

Plan: ____

____

____

____

Time spent counseling ___________ minutes

CHILD'S NAME:_______________________________ **Date of Birth:**____________ **Sex:** ☐ M ☐ F **Date of Visit:** ______________

ID # __________________ Enrolled in POC Program? Y / N

VITAL SIGNS (2nd Follow Up Visit)

HT ______ in/cm **WT** ______ lb/kg **Change in WT** ______ lb/kg **BMI** ______ kg/m² **BMI%** ______

BP ______ / ______ mmHg **BP** ______ / ______ mmHg **Average BP:** ______ / ______ mmHg **BP %ile:**______

BP Category: ☐ normal ☐ pre-hypertensive ☐ hypertensive

DIAGNOSES AND CO-MORBIDITIES

☐ No existing
☐ Abnormal lipids
☐ Abnormal weight gain
☐ Acanthosis nigricans
☐ Asthma
☐ Disordered Eating *(binge, food seeking, etc)*
☐ GERD
☐ Elevated blood pressure; hypertension (not diagnosed)
☐ Hypertension
☐ Mental Illness (e.g. Depression, Anxiety)
☐ Elevated liver enzymes
☐ NASLD or NASH
☐ Metabolic syndrome
☐ Orthopedic issues/ joints/ bone problems
☐ Overweight
☐ Obesity
☐ Abnormal menses
☐ Polycystic ovarian syndrome
☐ Pre- Diabetes
☐ Snoring
☐ Sleep Apnea
☐ Other ____________________________

BEHAVIORAL ASSESSMENT - 2nd Follow up Visit

Did the family attempt the goal set during the initial visit? ☐Yes ☐No **Was it a successful attempt?** ☐Yes ☐No

Were any tracking forms returned? ☐ Yes ☐ No Which one? ____________________________

Relevant Findings: ____

____

Nutritional Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Was a 3-day food diary returned? ☐ Yes ☐ No Relevant Findings: ____________________________

____

Comments: ____

____

Activity Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Family/Patient Concerns. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Is the child/family ready to make an additional change(s)? ☐ Yes ☐ No

Was a target behavior (s) identified (only for those who are engaged and ready)? ☐ Yes ☐ No

If so, what:

☐ Increase physical activity
☐ Decrease screen time
☐ Eat breakfast daily
☐ Eat more family meals
☐ Eat less fast food
☐ Eat more fruits & vegetables
☐ Reduce sugary beverages
☐ Regulate portion sizes
☐ Structure eating patterns
☐ Structure sleeping patterns
☐ Change dairy habits

What handouts were the family given? Note in the initial visit form.

What specific goal (s) was/were set? ____

____

____

____

Plan: ____

____

____

____

Time spent counseling ___________ minutes

CHILD'S NAME:______________________________ **Date of Birth:**____________ **Gender:** ☐ M ☐ F **Date of Visit:** ______________

ID # __________________ Enrolled in POC Program? Y / N

VITAL SIGNS (3rd Follow Up Visit)

HT ______ in/cm **WT** ______ lb/kg **Change in WT** ______ lb/kg **BMI** ______ kg/m² **BMI%** ______

BP ______ / ______ mmHg **BP** ______ / ______ mmHg **Average BP:** ______ / ______ mmHg **BP %ile:**______

BP Category: ☐ normal ☐ pre-hypertensive ☐ hypertensive

DIAGNOSES AND CO-MORBIDITIES

☐ No existing
☐ Abnormal lipids
☐ Abnormal weight gain
☐ Acanthosis nigricans
☐ Asthma
☐ Disordered Eating *(binge, food seeking, etc)*
☐ GERD
☐ Elevated blood pressure; hypertension (not diagnosed)
☐ Hypertension
☐ Mental Illness (e.g. Depression, Anxiety)
☐ Elevated liver enzymes
☐ NASLD or NASH
☐ Metabolic syndrome
☐ Orthopedic issues/ joints/ bone problems
☐ Overweight
☐ Obesity
☐ Abnormal menses
☐ Polycystic ovarian syndrome
☐ Pre- Diabetes
☐ Snoring
☐ Sleep Apnea
☐ Other ___________________________

BEHAVIORAL ASSESSMENT - 3rd Follow up Visit

Did the family attempt the goal set during the initial visit? ☐Yes ☐No **Was it a successful attempt?** ☐Yes ☐No

Were any tracking forms returned? ☐ Yes ☐ No Which one? ____________________________

Relevant Findings: ____

____

Nutritional Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Was a 3-day food diary returned? ☐ Yes ☐ No Relevant Findings: ___________________________

____

Comments: ____

____

Activity Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Family/Patient Concerns. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Is the child/family ready to make an additional change(s)? ☐ Yes ☐ No

Was a target behavior (s) identified (only for those who are engaged and ready)? ☐ Yes ☐ No

If so, what:

☐ Increase physical activity
☐ Decrease screen time
☐ Eat breakfast daily
☐ Eat more family meals
☐ Eat less fast food
☐ Eat more fruits & vegetables
☐ Reduce sugary beverages
☐ Regulate portion sizes
☐ Structure eating patterns
☐ Structure sleeping patterns
☐ Change dairy habits

What handouts were the family given? Note in the initial visit form.

What specific goal (s) was/were set? ____

____

____

____

Plan: ____

____

____

____

Time spent counseling ___________ minutes

CHILD'S NAME:______________________________ **Date of Birth:**____________ **Gender:** ☐ M ☐ F **Date of Visit:** ______________

ID # __________________ Enrolled in POC Program? Y / N

VITAL SIGNS (4th Follow Up Visit)

HT ______ in/cm **WT** ______ lb/kg **Change in WT** ______ lb/kg **BMI** ______ kg/m² **BMI%** ______

BP ______ / ______ mmHg **BP** ______ / ______ mmHg **Average BP:** ______ / ______ mmHg **BP %ile:**______

BP Category: ☐ normal ☐ pre-hypertensive ☐ hypertensive

DIAGNOSES AND CO-MORBIDITIES

- ☐ No existing
- ☐ Abnormal lipids
- ☐ Abnormal weight gain
- ☐ Acanthosis nigricans
- ☐ Asthma
- ☐ Disordered Eating *(binge, food seeking, etc)*
- ☐ GERD
- ☐ Elevated blood pressure; hypertension (not diagnosed)
- ☐ Hypertension
- ☐ Mental Illness (e.g. Depression, Anxiety)
- ☐ Elevated liver enzymes
- ☐ NASLD or NASH
- ☐ Metabolic syndrome
- ☐ Orthopedic issues/ joints/ bone problems
- ☐ Overweight
- ☐ Obesity
- ☐ Abnormal menses
- ☐ Polycystic ovarian syndrome
- ☐ Pre- Diabetes
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Other ___________________________

BEHAVIORAL ASSESSMENT - 4th Follow up Visit

Did the family attempt the goal set during the initial visit? ☐Yes ☐No **Was it a successful attempt?** ☐Yes ☐No

Were any tracking forms returned? ☐ Yes ☐ No Which one? ______________________________

Relevant Findings: ____

____

Nutritional Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Was a 3-day food diary returned? ☐ Yes ☐ No Relevant Findings: ____________________________

____

Comments: ____

____

Activity Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Family/Patient Concerns. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Is the child/family ready to make an additional change(s)? ☐ Yes ☐ No

Was a target behavior (s) identified (only for those who are engaged and ready)? ☐ Yes ☐ No

If so, what:

- ☐ Increase physical activity
- ☐ Decrease screen time
- ☐ Eat breakfast daily
- ☐ Eat more family meals
- ☐ Eat less fast food
- ☐ Eat more fruits & vegetables
- ☐ Reduce sugary beverages
- ☐ Regulate portion sizes
- ☐ Structure eating patterns
- ☐ Structure sleeping patterns
- ☐ Change dairy habits

What handouts were the family given? Note in the initial visit form.

What specific goal (s) was/were set? ____

____

____

____

Plan: ____

____

____

____

Time spent counseling ___________ minutes

CHILD'S NAME:_______________________________ **Date of Birth:**____________ **Gender:** ☐ M ☐ F **Date of Visit:** ______________

ID # ___________________ Enrolled in POC Program? Y / N

VITAL SIGNS (5th Follow Up Visit)

HT ______ in/cm **WT** ______ lb/kg **Change in WT** ______ lb/kg **BMI** ______ kg/m² **BMI%** ______

BP ______ / ______ mmHg **BP** ______ / ______ mmHg **Average BP:** ______ / ______ mmHg **BP %ile:**______

BP Category: ☐ normal ☐ pre-hypertensive ☐ hypertensive

DIAGNOSES AND CO-MORBIDITIES

☐ No existing
☐ Abnormal lipids
☐ Abnormal weight gain
☐ Acanthosis nigricans
☐ Asthma
☐ Disordered Eating *(binge, food seeking, etc)*
☐ GERD
☐ Elevated blood pressure; hypertension (not diagnosed)
☐ Hypertension
☐ Mental Illness (e.g. Depression, Anxiety)
☐ Elevated liver enzymes
☐ NASLD or NASH
☐ Metabolic syndrome
☐ Orthopedic issues/ joints/ bone problems
☐ Overweight
☐ Obesity
☐ Abnormal menses
☐ Polycystic ovarian syndrome
☐ Pre- Diabetes
☐ Snoring
☐ Sleep Apnea
☐ Other ___________________________

BEHAVIORAL ASSESSMENT - 5th Follow up Visit

Did the family attempt the goal set during the initial visit? ☐Yes ☐No **Was it a successful attempt?** ☐Yes ☐No

Were any tracking forms returned? ☐ Yes ☐ No Which one? ____________________________

Relevant Findings: ____

____

Nutritional Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Was a 3-day food diary returned? ☐ Yes ☐ No Relevant Findings: ___________________________

____

Comments: ____

____

Activity Re-assessment since last visit. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Family/Patient Concerns. ☐ No Change ☐ Relevant New Findings ☐ Resolved or Improved

Comments: ____

____

Is the child/family ready to make an additional change(s)? ☐ Yes ☐ No

Was a target behavior (s) identified (only for those who are engaged and ready)? ☐ Yes ☐ No

If so, what:

☐ Increase physical activity
☐ Decrease screen time
☐ Eat breakfast daily
☐ Eat more family meals
☐ Eat less fast food
☐ Eat more fruits & vegetables
☐ Reduce sugary beverages
☐ Regulate portion sizes
☐ Structure eating patterns
☐ Structure sleeping patterns
☐ Change dairy habits

What handouts were the family given? Note in the initial visit form.

What specific goal (s) was/were set? ____

____

____

____

Plan: ____

____

____

____

Time spent counseling ___________ minutes