



Reminder: When your completed packet is returned, a Nurse Coordinator will call to schedule your initial appointment.

- ➔ Packets can be faxed to 621-9191, mailed to 8101 Clearvista Pkwy #185, Indianapolis, IN 46256 Attn: WT MGMT, or dropped off at any office.
- ➔ For questions/concerns about weight management visits or the packet, please call 621-9273 for a return call.

Weight Management Appointments at Northpoint Pediatrics

Before we get started with your appointments to address any weight concerns, there are a few things you should know about us...

1. **WE WORK AS A TEAM.** Our main team consists of Ms. Teresa, Nurse Krista, and Dr. Liz Moore. The other HUGE part of the team is you. When whole families make changes together they are more successful. We use common sense, experience and research to help us pick behaviors that can work for YOUR FAMILY.
2. **WE CARE ABOUT YOUR WEIGHT BECAUSE IT CAN CAUSE HEALTH PROBLEMS FOR YOU.** We care about how much kids weigh because we want them to have fun, feel good and be able to do anything they want. We know that kids who are dealing with increased weight sometimes don't feel as good or can't do activities the way they want to do. Our goal for you: HAVE FUN, FEEL GOOD and DO WHAT YOU WANT.
3. **WE REALIZE THAT KIDS NEED TO WORK ON CHANGING BEHAVIORS DIFFERENTLY THAN ADULTS.** This is a big, important point. Unlike adults who make drastic changes abruptly, kids need to make a few small behavior changes and get good at them, then go on to the next set and get good at those also. (It is much like learning to dance or play a sport. You don't have the music and costumes or the state finals in the fieldhouse on the first day.)
4. **OUR GOALS WILL ALWAYS BE A SPECIFIC BEHAVIOR TO CHANGE AND OUR REWARDS WILL BE SPECIFIC AS WELL.** We will lead you through three steps to help with making behavior changes. **#1: Setting goals- goals are adding new behaviors or changing old behaviors.** (Example: I will walk 1 mile 3 times per

week OR I drink water instead of juice every day.) We use research, past experience and common sense to help you choose which behaviors to change next.

#2: Making changes- Changing those small behaviors with support and help from us.

#3: Rewarding yourself- These should also be specific. (Example: I did my change for 3 weeks so now I have earned a trip to the water park.)

Changing behaviors is hard, and we believe that you should be rewarded for doing that hard work with a fun activity or privilege. We do reserve the right to veto any reward that is not helpful in moving us toward the goal.

5. **WE DO NOT EXPECT YOU TO BE PERFECT.** When you really have a bad day, all we expect is for you to admit this wasn't the best day, think about what could help next time, then start again.

Some procedural things...

- ▶ Our voicemail is checked on most days of the week. Please don't use that voicemail for urgent issues because it will not be timely enough. If Teresa is not available, issues related to the weight management visits will be addressed by Dr. Moore or your primary physician. If you haven't had a response in 10 days after labs are drawn or 5 business days for a message, please call back.
- ▶ If you give us permission, we will leave you messages regarding these visits, labs or questions to the telephone number of your choice. This is to cut down on "phone tag" between our office and your family. If the number you want us to use changes, please let us know.
- ▶ Labs that we order will sometimes take one week to get results from the lab. If results are abnormal, sometimes Teresa will wait to discuss them with Dr. Moore and devise a plan after that discussion. Typically, we will wait to call you with any test results until we have all of them. Any lab results that may be critical will be reviewed as soon as possible and you would be called right away.

▶ There will be also be a shorter assessment form that needs to be filled out and returned before we will schedule any follow up appointments. You can find this on our website at www.northpointpeds.com. Our nurse will give you a call to schedule your appointment once your packet has been returned. There is also an example of completed forms on the website.

>>>>> Thanks for your time and attention. We are looking forward to helping you make changes and getting to celebrate each victory with you.

PT Name: _____ (# _____) Date: _____

Fill in chart with what you eat and drink—including how much.

	Day of week:	Day of week:	Day of week:
BREAKFAST			
LUNCH			
SNACK			
DINNER			
OTHER			

Fill in chart with how much time you spend on each activity.

	Day of week:	Day of week:	Day of week:
TV			
Computer			
Video games			
Exercise**			

**Please write what type of exercise you did.

Does this chart look like a typical week to you? _____

What is typical screen time on weekdays? _____ On weekends? _____

What is typical weekly exercise? (ex: gym class for 45 minutes on three days per week)

PT Name: _____ (# _____)Date: _____

Assessment Questions: for parents to fill out alone—page one

1. Circle the word that completes the sentence for you:

I am (not at all, a little, somewhat, moderately, very, extremely) concerned with my child's weight.

I feel (completely unsure, not very sure, don't know, moderately sure, very sure) that our family needs to make changes to the things we eat and have in our home.

I feel (completely unsure, not very sure, don't know, moderately sure, very sure) that our family needs to make changes to our lifestyle (ex: exercise, time spent watching screens, shopping)

I am interested in making changes for our family in what time frame? (today, in the next few weeks, in the next few months, someday.)

I feel (completely unsure, not very sure, don't know, moderately sure, very sure) that our family can be successful in making changes to our eating, activity and lifestyle.

2. What have you **tried in the past** to help your child lose or control their weight? (Include all weight loss diets, systems and supplements.)

3. Check all of the following concerns that apply to your child and/or family:

- | | |
|--|--|
| <input type="checkbox"/> snoring or mouth breathing | <input type="checkbox"/> inadequate or poor quality sleep |
| <input type="checkbox"/> TV/computer/phone in bedroom | <input type="checkbox"/> napping after school |
| <input type="checkbox"/> eating in front of TV/computer | <input type="checkbox"/> meals eaten in the car >1 time per week |
| <input type="checkbox"/> fast food for meals >1 time per week | <input type="checkbox"/> skipped meals |
| <input type="checkbox"/> concerns with your child's self-esteem or bullying | |
| <input type="checkbox"/> schedule too full to be able to add exercise activities | |

3. What **specific rewards** do you have in mind?

If none, what are your **child's interests and favorite activities**?

4. Do you have any **other concerns** we have not discussed?

Assessment Questions: for parents to fill out alone—page two

5. **Finish the sentence:**

The thing I am most worried about is _____
 _____.

The hardest part of helping my child with this is _____
 _____.

When I think about making changes, I feel _____
 _____.

If you want to get my kid to do something, you should _____
 _____.

My kid is really good at _____.

The thing I feel most confident that we could change first is _____
 _____.

The thing I hope you will help our family do is _____
 _____.

13. **FAMILY HISTORY:** Please check the following for any family history for your child. **Please include your child, all of their siblings, parents, aunts and uncles, cousins and grandparents.** For Grandparents, aunts, uncles and cousins, please indicate if it is maternal or paternal side of the family.

	NO	YES: <i>Who and at what age did it start?</i>
Obesity or overweight		
Elevated Blood Pressure		
Elevated Cholesterol/Lipids /Triglycerides		
Diabetes /Metabolic Syndrome		
Heart Attack/Coronary Artery Disease		
Stroke /TIA/Peripheral Vascular disease		
Pancreatitis or liver disease		
Joint replacement/disease		
Polycystic Ovary Syndrome or infertility		
Thyroid disease		
Reflux/Hiatal hernia		
Sleep Apnea		
Asthma		

PT Name: _____ (# _____)Date: _____

Assessment questions: for kids to fill out alone or with parents helping.

1. Fill in the blank/finish the sentence:

How do you feel about your weight? _____

Would you rather work on **what you eat** or **activities that you do** to help change your weight?

How **easy do you think it will be to make changes** to what you eat or do?

I am **most** worried about _____.

I wish you would **leave me alone** about _____.

If someone **really wants me to do something**, they should _____.

I am **really good** at _____.

The thing you could do that **would help the most** is _____.

The change that I think would be **best to try first** is _____.

2. Have you ever been **teased or bullied** about your weight?
When?

3. What **behaviors** should we work on changing today?

What **rewards** would you like to earn?

5. **Rank** (1 is first and 5 is last) the order that you would want to work on changing behaviors:

- | | | |
|-------------------|------------------|-------------------|
| ___ Drink Choices | ___ Food Choices | ___ Portion Sizes |
| ___ Exercise | ___ Screen Time | |

6. Please list **any other things** you want to talk about or questions you have.