PARENT QUESTIONNAIRE
(to be completed by parent/guardian of participant)

My Child's Name: ______________________________ Date: ___________________________
Birth Date: ______________________________________ Age: ____________________________
Parent(s) Name: ____

SECTION 1: Please read each statement and put a check (√) under YES or NO.

	YES	NO
1. I can fully participate in a weight management program with my child	☐	☐
2. I am having difficulties finding healthy ways to eat and feed my family	☐	☐
3. My child wants to participate in a weight management program	☐	☐

SECTION 2: Please read each statement and put a check (√) under YES or NO.

	YES	NO
1. Is your child concerned about his/her weight?	☐	☐
2. Is there a family history of eating disorders, substance abuse/alcoholism, or depression?	☐	☐
3. Have you noticed a change in your child's eating habits?	☐	☐
4. Is your child concerned with frequent weighing, compulsive exercise or compulsive weight control issues?	☐	☐

Additional Comments

____
____
____
____
____