Jefferson Pediatrics

Child Diet Revisit form: No.____

Name:______________ Completed by:_________________________ Date:________

Weight: Starting____/ Goal____ Last Visit:_____ Today:_____ Lost:______ Total Lost:____

What is new and good?

What things were implemented since?

What changes/ benefits are noted?

Sleep: Hours Before: Now: **Undisturbed/Disturbed:**

Eating patterns: Duration: Total Meals/Snacks: Chewing:

Appetite pattern: Hunger Jitter: Can't wait to eat Euglycemic State:

True Hunger: 4-5 hours off last meal- comes on slowly and easily manageable, low glucose level

False Hunger: Hungry within 4 hours of last meal – Feel like eating although not hungry

Moods: Stable Happy Frustrated Angry Sad

Clarity of mind and thought:

HW/Reading/Writing/Grades:

More time/energy: (For things to enjoy)

Frequent Urination: Bowel Movements: Other Symptoms/Complains:

Daily Exercises/Activities:

Family Life:

Plan: 1.____

2.____

3.____