Deaconess
WEIGHT LOSS
SOLUTIONS

Thank you for your interest in our programs. You are taking a step towards better health.

This packet contains information about our nonsurgical weight loss program, Healthy Eating and Living Program (HELP). We understand that weight loss is a journey and want to provide the path that fits your lifestyle best. Our mission is to provide support and education for the lifelong journey that is weight loss and weight maintenance.

The **Healthy Eating and Living Program (HELP)** provides numerous visit options which we tailor to the individual needs of our patients. Visits include time with the medical provider, dietitian and exercise specialist. The program includes nutrition classes which can be completed online or zoom meetings, logging food, and physical activity. We may also recommend medical testing (i.e. labs or sleep study).

Prior to your first appointment, the following steps must be completed:

1. We ask that you complete all new patient paperwork for the bariatric providers to review. Once the paperwork is completed, return it to our office by fax to 812-858-6843 or mail to 4219 Gateway Blvd., Ste. 2001, Newburgh, IN 47630. Once your medical information is reviewed by our provider, we will call to schedule your initial consultation.

2. Prior to us scheduling your new patient appointment our provider will review your paperwork as well as your insurance information will be submitted to the hospital verification department. They will confirm your insurance requirements and benefits to determine if your plan has bariatric coverage. Should you desire to know your benefits prior to your first visit, you can contact your insurance company.

Once the above steps have been completed, we will contact you and review your insurance coverage and schedule your initial appointment. The first appointment may last up to 3 hours. The provider will do the initial exam, take a comprehensive history, provide an overview of the program, and make a recommendation. The exercise specialist will do an In-Body exam, and go over exercise options. The dietitian will review the program requirements, such as keeping food logs and taking nutrition classes.

You are worth the time and dedication to this program and our team is here to support you every step of the way.

Please feel free to contact our office if you have any questions about our programs. We look forward to helping you reach success with your health goals.

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HEALTHY EATING AND LIVING PROGRAM REQUIREMENTS

Please read the non-surgical program requirements, initial each box and submit a signed copy with your New Patient Packet documents.

- ❑ 1. Meeting with the Registered Dietitian and Exercise Specialist along with your provider is a requirement of this program. You may have some follow ups with only the Registered Dietitian and Exercise Specialist throughout the program. If your insurance does not cover nutrition visits, you will be responsible for the remaining balance. *If you have Medicare or a Medicare-based insurance your nutrition visits may be a non-covered service.*
- ❑ 2. Food and exercise logs are required for the program. Please bring logs monthly to each nutrition visit (with the exception of initial visit). If no logs are submitted within the first 60 days of your initial visit you may be deemed as non-compliant and may be terminated from the program.
- ❑ 3. Must be drug-free 6 months prior to starting the program and remain drug-free for the entire length of the program.
- ❑ 4. Patient cannot have an uncontrolled psychiatric disease or a recent psychiatric hospitalization within the past 6 months.
- ❑ 5. Appointment time slots are in high demand. If you are an established patient, this may result in termination from the program after the second no-show.
- ❑ 6. Nutrition classes are required and each patient will need to complete at least 6 classes. These classes can be done online. More information will be given at your first visit.
- ❑ 7. If your insurance company approves of bariatric services, please keep in mind that some services may not be covered; please financially plan to have funds available to cover routine items such as labs.
- ❑ 8. Some patients may need additional testing such as chest x-ray, EKG, and/or sleep study, and additional labs. Please know this is a part of your weight loss journey and highly recommended to uncover any additional medical issues. Some of the tests may be out-of-pocket expenses if not covered by your insurance.

I acknowledge I have read and understand the information above, and my signature states I will comply with the program requirements. Failure to comply with program requirements may result in dismissal from the program.

Guardian Signature _____ Date _____

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Welcome to Deaconess Weight Loss Solutions,

During each of your visits you will be seen by a clinic provider, exercise specialist and one of our dietitians. Please review the **important patient notification below:**

- Weight Loss Solutions is an outpatient department of Deaconess Hospital. As such, your insurance company will be billed:
  1. A facility fee for the services
  2. A nutrition charge for the dietitian's services
  3. A professional fee for services provided by our provider

Thank you for allowing us to take care of you. We will make every attempt to honor appointment times. Unavoidable delays may occur at times. We welcome your feedback in helping us provide quality care to you. Please complete the Patient Satisfaction Survey that you will get by email, phone call or text. If you have any questions or concerns about the information, please call our office and we will be happy to assist you.

Sincerely,
Deaconess Weight Loss Solutions Staff

My signature below indicates I have read and understand the information above.

Guardian Signature _____ Date _____

PATIENT INFORMATION

Patient Name: _____

Street Address: _____

Mailing Address: _____

Phone Numbers: _____

Date of Birth: _____ Social Security #: _____

Email:_____

Sex: ❑ Male ❑ Female ❑ Other_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer:_____ Employer Phone:_____

Employer Address: _____

Spouse Name:_____ Spouse Phone: _____

Spouse Date of Birth:_____ Spouse Social Security #: _____

Spouse Employer:_____

Emergency Contact:_____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Secondary Insurance Company Name: _____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Tertiary Insurance Company Name:_____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Please provide a copy of your insurance card(s), front and back, via fax, email or mail, along with the completion of the insurance information above.

MEDICAL HISTORY

Patient Name:_____Date of Birth: _____

Who is Your Primary Care Provider (PCP): _____

PCP Address:_____ PCP Phone: _____

Have you ever had a bariatric surgery or procedure?: ❑ Yes ❑ No

If yes, what kind?: ❑ Lap Band ❑ Sleeve ❑ Nissen ❑ Gastric Balloon ❑ Gastric Bypass

When was the Surgery?:_____

Where did You have the Surgery?:_____

Height:_____ Weight:_____ BMI:_____

Medical Condition your are **CURRENTLY** being treated:		
Condition:		Year Diagnosed:
❑	Acid Reflux (GERD)	
❑	Anxiety	
❑	Arthritis	
❑	Asthma	
❑	Back Pain	
❑	Bipolar Disorder	
❑	Cancer	
❑	Crohn's Disease	
❑	Ulcerative Colitis	
❑	Depression	
❑	Diabetes	
❑	High Blood Pressure	
❑	High Cholesterol	
❑	Joint Pain	
❑	Thyroid Cancer	
❑	Sleep Apnea ❑ C-Pap ❑ Bi-Pap	

Are you currently on dialysis?	❑ Yes	❑ No
Are you on a transplant list?	❑ Yes	❑ No
Do you have a single kidney?	❑ Yes	❑ No
Are you wheelchair bound?	❑ Yes	❑ No
Do you currently use oxygen?	❑ Yes	❑ No

Medications (Name/Dose/Frequency)

Medication Allergies	
Medicine	Reaction

Ever been treated for binge eating?	❑ Yes	❑ No
Ever had surgery outside of the USA?	❑ Yes	❑ No
Do you have a family history of thyroid cancer?	❑ Yes	❑ No
Ever had Pancreatitis?	❑ Yes	❑ No
Ever been diagnosed with MEN?	❑ Yes	❑ No

SOCIAL HISTORY

Do you drink alcohol? ❑ Yes ❑ No

If yes, how often do you drink? _____

If yes, how many drinks/day? _____

Did you drink heavily in the past? ❑ Yes ❑ No

If yes, do you still? _____

If you stopped drinking, when did you stop? _____

Do you currently use illegal drugs? ❑ Yes ❑ No

Have you used drugs in the past? ❑ Yes ❑ No

When did you start using? _____

When did you stop using? _____

What drugs/substances do you use?

_____

_____

Do you currently smoke? ❑ Yes ❑ No

If yes, how many packs/day? _____

When did you start smoking? _____

Are you willing to quit? ❑ Yes ❑ No

Did you previously smoke? ❑ Yes ❑ No

When did you quit? _____

Did you use e-cigarettes? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

How frequently? _____

SURGICAL AND HOSPITALIZATION HISTORY

Dates Type of Surgery or Reason for Hospitalization

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

If you are unaware of your family history, please document here: _____

Relative	Arthritis	Cancer	Diabetes	Heart Attack	Heart Disease	High Blood Pressure	Liver Disease	Lung Disease	Obesity	Sleep Apnea	Stroke	Age/Cause of Death
Mother												
Father												
Maternal Grandmother												
Maternal Grandfather												
Paternal Grandmother												
Paternal Grandfather												
Sibling 1												
Sibling 2												
Sibling 3												
Sibling 4												

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EPWORTH SLEEPINESS SCALE

Patient Name: _____

Today's Date:_____ Patient's Age:_____

Sex: ❑ Male ❑ Female ❑ Other_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? **This refers to your usual way of life in recent times.**

Even if you have done some of these things recently, please try to indicate how they **might** have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = You would **never** doze off.
1 = There is a **slight** chance of your dozing off.
2 = There is a **moderate** chance of you dozing off.
3 = There is a **high** chance of you dozing off.

Situation	**Chance of You Dozing Off**
Sitting and reading	_____
Watching TV	_____
Sitting inactive, in a public place (such as a theatre, a meeting, etc.)	_____
As a passenger in a car for one hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
YOUR TOTAL:	_____

Score:

0 to 10 Normal Range | 10 to 12 Borderline | 12 to 24 Abnormal Range

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Name _____ CSN (office use only) _____

Date of Birth _____ MRN (office use only) _____

NUTRITION ASSESSMENT QUESTIONNAIRE

Welcome to Deaconess Weight Loss Solutions. We look forward to supporting you in your journey to better health through weight loss. Please answer all of the following questions. If a question does not apply to you, answer with N/A.

GENERAL INFORMATION

Why are you seeking a weight loss program? How do you see this benefiting you?

SPECIAL DIETS

Are you currently on a special diet? ☐ YES ☐ NO

If yes, who prescribed it? _____

What is your currently prescribed diet

☐ Low fat ☐ Low Salt
☐ Carbohydrate Controlled
☐ Other _____

FOOD ALLERGIES

Please list any food allergies or intolerances: (e.g., lactose intolerance, shellfish, gluten, etc.)

EATING ISSUES

☐ **YES** ☐ **NO** Wake up in the middle of the night and eat

☐ **YES** ☐ **NO** Wake up in the morning to find evidence that you have eaten, but you don't remember the episode

☐ **YES** ☐ **NO** Frequently skip meals

☐ **YES** ☐ **NO** Frequently crave sweets during the day

☐ **YES** ☐ **NO** Frequently fast as a part of your diet plan

☐ **YES** ☐ **NO** Are you a vegetarian (check one):
☐ Vegan ☐ Vegetarian
☐ Octo-lacto ☐ Octo ☐ Lacto

☐ **YES** ☐ **NO** Drink alcoholic beverages (If yes, how often do you drink?) _____

☐ **YES** ☐ **NO** Feel that there are foods that you cannot live without

☐ **YES** ☐ **NO** Experience problems with chewing or swallowing

If you checked yes on any of the above, please explain:

ENVIRONMENTAL ISSUES THAT AFFECT YOUR WEIGHT

☐ **YES** ☐ **NO** Occupational (working around food/no time for lunch)
☐ **YES** ☐ **NO** Sleep
☐ **YES** ☐ **NO** Travel
☐ **YES** ☐ **NO** Household (family/obligations/schedule)
☐ **YES** ☐ **NO** Shopping or cooking
☐ **YES** ☐ **NO** Meals eaten away from home

If you checked yes on any of the above, please explain:

PLEASE CHECK ALL THAT APPLY

I get my groceries at:

☐ Grocery Store
☐ Convenience Store
☐ Food Stamps
☐ Food Banks
☐ Farmer Market
☐ Other

☐ **YES** ☐ **NO** Do you have any issues purchasing nutritious foods?

☐ **YES** ☐ **NO** Do you have access to a kitchen?

If you DO NOT have a good food supply for the month, how long does your food supply last?

☐ 3 weeks ☐ 2 weeks ☐ 1 week

If you do not have an adequate food supply for the entire month, what do you do?

ADDITIONAL QUESTIONS

How long have you been overweight or obese?

Were you overweight as a child?

How much weight do you want to lose?

Who does the grocery shopping?

Who prepares the meals in your home?

On average how many non-starchy vegetables do you eat daily?

On average how many fruits do you eat daily?

SUPPORT STRUCTURE

List the people who will be there to support you during your weight loss journey.

FOR WOMEN ONLY

Do you have plans to become pregnant within the next year?

☐ **YES** ☐ **NO**

Deaconess Clinic

PERMISSION TO DISCUSS MY CARE

Patient name	Birthdate

I permit the following information to be discussed with those of my family, friends or others listed below. I understand that if I want any of these persons to receive a copy of my records, I must complete and sign a separate 'Authorization' or 'Release of Information' form. Copies of my complete record can be obtained through the Medical Records Department. Copies of individual test results or office notes can be obtained from the physician office.

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

Discussion of results or plan of care will not include mental health counseling sessions, for which a separate form is required.

In an emergency or if admitted to the hospital and unable to make my wishes known, I understand that my doctor and hospital staff may rely on the above permission to determine with whom they may discuss my care.

The above permissions can be changed by me at any time by notifying my doctor's office, Medical Records or the Deaconess Health System Privacy Officer.

_____ _____
Patient signature Date

_____
Printed name

_____ _____
Signature of lawful personal representative * Telephone

_____
Printed name

*Required only if patient is a minor or unable to represent self

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) **Not At All**	*(1)* **Several Days**	*(2)* **More Than Half the Days**	*(3)* **Nearly Every Day**
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

Name: _____ **Date**: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When I feel frightened, it is hard for me to breathe	o	o	o
2.	I get headaches when I am at school	o	o	o
3.	I don't like to be with people I don't know well	o	o	o
4.	I get scared if I sleep away from home	o	o	o
5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
9.	People tell me that I look nervous	o	o	o
10.	I feel nervous with people I don't know well	o	o	o
11.	My I get stomachaches at school	o	o	o
12.	When I get frightened, I feel like I am going crazy	o	o	o
13.	I worry about sleeping alone	o	o	o
14.	I worry about being as good as other kids	o	o	o
15.	When I get frightened, I feel like things are not real	o	o	o
16.	I have nightmares about something bad happening to my parents	o	o	o
17.	I worry about going to school	o	o	o
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 2 of 2 (To be filled out by the CHILD)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	I worry about things working out for me	o	o	o
22.	When I get frightened, I sweat a lot	o	o	o
23.	I am a worrier	o	o	o
24.	I get really frightened for no reason at all	o	o	o
25.	I am afraid to be alone in the house	o	o	o
26.	It is hard for me to talk with people I don't know well	o	o	o
27.	When I get frightened, I feel like I am choking	o	o	o
28.	People tell me that I worry too much	o	o	o
29.	I don't like to be away from my family	o	o	o
30.	I am afraid of having anxiety (or panic) attacks	o	o	o
31.	I worry that something bad might happen to my parents	o	o	o
32.	I feel shy with people I don't know well	o	o	o
33.	I worry about what is going to happen in the future	o	o	o
34.	When I get frightened, I feel like throwing up	o	o	o
35.	I worry about how well I do things	o	o	o
36.	I am scared to go to school	o	o	o
37.	I worry about things that have already happened	o	o	o
38.	When I get frightened, I feel dizzy	o	o	o
39.	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	o	o	o
41.	I am shy	o	o	o

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date**: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When my child feels frightened, it is hard for him/her to breathe	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	My child worries about things working out for him/her	o	o	o
22.	When my child gets frightened, he/she sweats a lot	o	o	o
23.	My child is a worrier	o	o	o
24.	My child gets really frightened for no reason at all	o	o	o
25.	My child is afraid to be alone in the house	o	o	o
26.	It is hard for my child to talk with people he/she doesn't know well	o	o	o
27.	When my child gets frightened, he/she feels like he/she is choking	o	o	o
28.	People tell me that my child worries too much	o	o	o
29.	My child doesn't like to be away from his/her family	o	o	o
30.	My child is afraid of having anxiety (or panic) attacks	o	o	o
31.	My child worries that something bad might happen to his/her parents	o	o	o
32.	My child feels shy with people he/she doesn't know well	o	o	o
33.	My child worries about what is going to happen in the future	o	o	o
34.	When my child gets frightened, he/she feels like throwing up	o	o	o
35.	My child worries about how well he/she does things	o	o	o
36.	My child is scared to go to school	o	o	o
37.	My child worries about things that have already happened	o	o	o
38.	When my child gets frightened, he/she feels dizzy	o	o	o
39.	My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	o	o	o
41.	My child is shy	o	o	o

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

ID# _____

Date:_____

PedsQL™

General Well-Being Scale

Standard Version

CHILD REPORT (ages **8-12**)

DIRECTIONS

Please tell us **how much each sounds like you** during the **past ONE month** by circling:

0 if it **never** sounds like you
1 if it **almost never** sounds like you
2 if it **sometimes** sounds like you
3 if it **often** sounds like you
4 if it **almost always** sounds like you

There are no right or wrong answers.
If you do not understand a question, please ask for help.

*In the past **ONE month**, how much does this **sound like you** …*

ABOUT ME	**Never**	**Almost Never**	**Some-times**	**Often**	**Almost Always**
1. I feel happy	0	1	2	3	4
2. I feel good about myself	0	1	2	3	4
3. I feel good about my health	0	1	2	3	4
4. I get support from my family or friends	0	1	2	3	4
5. I think good things will happen to me	0	1	2	3	4
6. I think my health will be good in the future	0	1	2	3	4

*In the past **ONE month**…*

IN GENERAL…	**Bad**	**Fair**	**Good**	**Very Good**	**Excellent**
1. In general, how is your health?	0	1	2	3	4

ID# _____

Date:_____

PedsQL™

General Well-Being Scale

Standard Version

PARENT REPORT for **CHILDREN** (ages **8-12**)

DIRECTIONS

Please tell us **how much each sounds like your child** during the **past ONE month** by circling:

0 if it **never** sounds like your child
1 if it **almost never** sounds like your child
2 if it **sometimes** sounds like your child
3 if it **often** sounds like your child
4 if it **almost always** sounds like your child

There are no right or wrong answers.
If you do not understand a question, please ask for help.

*In the past **ONE month**, how much does this **sound like your child** …*

WELL-BEING	**Never**	**Almost Never**	**Some-times**	**Often**	**Almost Always**
1. Feels happy	0	1	2	3	4
2. Feels good about himself or herself	0	1	2	3	4
3. Feels good about his or her health	0	1	2	3	4
4. Gets support from family or friends	0	1	2	3	4
5. Thinks good things will happen to him or her	0	1	2	3	4
6. Thinks his or her health will be good in the future	0	1	2	3	4

*In the past **ONE month …***

IN GENERAL…	**Bad**	**Fair**	**Good**	**Very Good**	**Excellent**
1. In general, how is your child's health?	0	1	2	3	4