Pizzi Healthy Weight Management Assessment (PHWMA)
Adult version (21 and over)
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Name: _____**Age:** _____**Ht:**_____**Weight:**_____

Date: _____ **Gender (circle one):** Male Female Other _____

Ethnicity (circle one): White Hispanic/Latin African American Asian Other _____

Are there overweight individuals you live with: YES NO **How many?:** 1 2 3 4 5+

Your relationship with each person: _____

INSTRUCTIONS

Use the following numbers to tell me if you would like to make changes in that category

1 I do not want to make changes in this area

2 I am considering making a change in this area

3 I have already started to make changes in this area

4 I need to maintain or keep the behavior/changes in this area - no change needed

Category	**Want to change? (circle one)**
Choosing play, fun or leisure activities	1 2 3 4
Doing play, fun or leisure activities	1 2 3 4
Getting ready for work or other activity	1 2 3 4
Keeping a schedule of activity	1 2 3 4
My physical health	1 2 3 4
Eating habits and routines (e.g. in front of the TV, eating too late at night)	1 2 3 4
Time spent in front of the TV or computer	1 2 3 4
Eating junk food and fast food	1 2 3 4
Eating fruits and vegetables	1 2 3 4

Being able to keep my attention on one thing at a time	1 2 3 4
Being more active	1 2 3 4
Spending time with family	1 2 3 4
Amount of sweets eaten each day	1 2 3 4
My weight	1 2 3 4
My friends	1 2 3 4
Feeling safe	1 2 3 4
Being happy	1 2 3 4
My overall coping abilities (can you deal with things ok?)	1 2 3 4
Feeling confident	1 2 3 4
Being able to deal with change	1 2 3 4
Doing things I like to do	1 2 3 4
How much I participate in sports or outdoor activities	1 2 3 4
How much I sleep	1 2 3 4

LIST ANY IDEAS YOU MAY HAVE TO MAKE CHANGES IN THAT CATEGORY

Category	**What do you think can be done to improve this area?**
Choosing play, fun or leisure activities	
Doing play, fun or leisure activities	
Getting ready for work or other activity	
Keeping a schedule of activity	
My physical health	
Eating habits and routines (e.g. in front of the TV, eating too late at night)	

Time spent in front of the TV or computer	
Eating junk food and fast food	
Eating fruits and vegetables	
Being able to keep my attention on one thing at a time	
Being more active	
Spending time with family	
Amount of sweets eaten each day	
My weight	
My friends	
Feeling safe	
Being happy	
My overall coping abilities (can you deal with things ok?)	
Feeling confident	
Being able to deal with change	
Doing things I like to do	
How much I participate in sports or outdoor activities	
How much I sleep	

USING THIS SCALE, PLEASE STATE HOW STRESSFUL EACH CATEGORY WOULD BE IF YOU WERE TO MAKE A CHANGE IN THAT AREA:

0 Not Stressful

1 Sometimes Stressful

2 Very Stressful

Category	**How stressful is this area for you? (circle one)**		
	Not	Sometimes	Very
Choosing play, fun or leisure activities	0	1	2
Doing play, fun or leisure activities	0	1	2
Getting ready for work or other activity	0	1	2
Keeping a schedule of activity	0	1	2
My physical health	0	1	2
Eating habits and routines (e.g. in front of the TV, eating too late at night)	0	1	2
Time spent in front of the TV or computer	0	1	2
Eating junk food and fast food	0	1	2
Eating fruits and vegetables	0	1	2
Being able to keep my attention on one thing at a time	0	1	2
Being more active	0	1	2
Spending more time with family	0	1	2
Amount of sweets eaten each day	0	1	2
My weight	0	1	2
My friends	0	1	2
Feeling safe	0	1	2
	0	1	2

Being happy	
My overall coping abilities (can you deal with things ok?)	0 1 2
Feeling confident	0 1 2
Being able to deal with change	0 1 2
Doing things I like to do	0 1 2
How much I participate in sports or outdoor activities	0 1 2
How much I sleep	0 1 2

PLEASE INDICATE IF YOU THINK YOU NEED COACHING TO MAKE CHANGES IN THESE AREAS? PROVIDE A COMMENT IF NEEDED.

Category	**Circle Yes or NO**	**Comments**
Choosing play, fun or leisure activities	Yes No	
Doing play, fun or leisure activities	Yes No	
Getting ready for work or other activity	Yes No	
Keeping a schedule of activity	Yes No	
My physical health	Yes No	
Eating habits and routines (e.g. in front of the TV, eating too late at night)	Yes No	
Time spent in front of the TV or computer	Yes No	
Eating junk food and fast food	Yes No	
Eating fruits and vegetables	Yes No	
Being able to keep my attention on one thing at a time	Yes No	
Being more active	Yes No	

Spending more time with family	Yes No	
Amount of sweets eaten each day	Yes No	
My weight	Yes No	
My friends	Yes No	
Feeling safe	Yes No	
Being happy	Yes No	
My overall coping abilities (can you deal with things ok?)	Yes No	
Feeling confident	Yes No	
Being able to deal with change	Yes No	
Doing things I like to do	Yes No	
How much I participate in sports or outdoor activities	Yes No	
How much I sleep	Yes No	

FROM THE CATEGORIES LISTED ABOVE **CHOOSE THE TOP FIVE AREAS** THAT YOU WOULD LIKE TO WORK ON. LIST THE MOST IMPORTANT AS NUMBER 1.

Please write the area/category you would like to see changes made under the number	1	2	3	4	5
Reason I want to make this change					
I feel can make this change by myself without help : Yes No					
Type of help I think I need to make changes in the area listed					

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