Pizzi Healthy Weight Management Assessment (PHWMA)
Child/Youth Version
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Name: _____
Date:_____
Age: _____ Height: _____ Weight: _____

INSTRUCTIONS

Please use the following numbers to tell me if you want to make changes in that area
1 I do not want to change this area

2 I am thinking about making a change in this area

3 I have decided to make a change in this area

4 I already started making changes in this area

5 I need to maintain or keep my behavior/changes I have made in this area

Category	**Want to change? Circle your answer**
Able to choose play, fun or leisure activities for myself	1 2 3 4 5
Doing play, fun or leisure activities	1 2 3 4 5
Getting ready for school	1 2 3 4 5
Keeping a schedule for things I do in my day	1 2 3 4 5
My physical health	1 2 3 4 5
Eating habits and routines (e.g. in front of the TV, eating too late at night)	1 2 3 4 5
Time I spend in front of the TV or on a computer	1 2 3 4 5
Eating junk food and fast food	1 2 3 4 5
Eating fruits and vegetables	1 2 3 4 5
Being able to study	1 2 3 4 5
Being able to learn	1 2 3 4 5
Spending time with family	1 2 3 4 5

Amount of sweets eaten each day	1 2 3 4 5
My weight	1 2 3 4 5
My friends	1 2 3 4 5
Feeling safe in school	1 2 3 4 5
My happiness	1 2 3 4 5
My overall coping abilities (can I deal with things ok?)	1 2 3 4 5
Where I live	1 2 3 4 5
Feeling safe at home	1 2 3 4 5
My ability to deal with change	1 2 3 4 5
Doing things I like to do	1 2 3 4 5
How much I participate in sports or outdoor activities	1 2 3 4 5
How much I sleep	1 2 3 4 5

Please list any ideas to make changes in this area

Category	**What do you think can be done to make each area better for you?**
Able to choose play, fun or leisure activities for myself	
Doing play, fun or leisure activities	
Getting ready for school	
Keeping a schedule for things I do in my day	
My physical health	
Eating habits and routines (e.g. in front of the TV, eating too late at night)	
Time I spend in front of the TV or on a computer	
Eating junk food and fast food	
Eating fruits and vegetables	
Being able to study	

Being able to learn	
Spending time with family	
Amount of sweets eaten each day	
My weight	
My friends	
Feeling safe in school	
My happiness	
My overall coping abilities (can I deal with things ok?)	
Where I live	
Feeling safe at home	
My ability 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 let me know how stressful each area is for you:

2 Very stressful

1 Sometimes Stressful

0 Not stressful

Category	**How stressful is this area? (0-2)**
Able to choose play, fun or leisure activities for myself	2 1 0
Doing play, fun or leisure activities	2 1 0
Getting ready for school	2 1 0
Keeping a schedule for things I do in my day	2 1 0

My physical health	2 1 0
Eating habits and routines (e.g. in front of the TV, eating too late at night)	2 1 0
Time I spend in front of the TV or on a computer	2 1 0
Eating junk food and fast food	2 1 0
Eating fruits and vegetables	2 1 0
Being able to study	2 1 0
Being able to learn	2 1 0
Spending time with family	2 1 0
Amount of sweets eaten each day	2 1 0
My weight	2 1 0
My friends	2 1 0
Feeling safe in school	2 1 0
My happiness	2 1 0
My overall coping abilities (can I deal with things ok?)	2 1 0
Where I live	2 1 0
Feeling safe at home	2 1 0
My ability to deal with change	2 1 0
Doing things I like to do	2 1 0
How much I participate in sports or outdoor activities	2 1 0
How much I sleep	2 1 0

For the following, Circle Yes or No

Category	**Do you think you want to work on this area? Yes or No**	**Comments**
Able to <u>choose</u> play, fun or leisure activities for myself	Yes No	

Doing play, fun or leisure activities	Yes No	
Getting ready for school	Yes No	
Keeping a schedule for things I do in my day	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 I spend in front of the TV or on a computer	Yes No	
Eating junk food and fast food	Yes No	
Eating fruits and vegetables	Yes No	
Being able to study	Yes No	
Being able to learn	Yes No	
Spending time with family	Yes No	
Amount of sweets eaten each day	Yes No	
My weight	Yes No	
My friends	Yes No	
Feeling safe in school	Yes No	
My happiness	Yes No	
My overall coping abilities (can I deal with things ok?)	Yes No	
Where I live	Yes No	
Feeling safe at home	Yes No	
My ability 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 TOP FIVE AREAS** THAT YOU WOULD LIKE TO WORK ON. LIST THE MOST IMPORTANT AS NUMBER 1.

Please write the Category under the number	1	2	3	4	5
Area to change					
Reason I want to make this change					
I feel I can make this change by myself /without help Yes No					
Type of help I might need to make changes					

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