

**Healthy Active Living
Clinical Care Encounter Form**
Health Supervision Visits 2-17 years



Practice Name _____ **Provider Name** _____

Date of Visit _____ Date of Birth _____ Male Female

BMI % _____ Blood Pressure* ____/____

- | | | | |
|---|--------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> BMI <5% (underweight) | <u>INITIAL</u> | <u>BLOOD PRESSURE</u> | <u>%REPEAT (if indicated)</u> |
| <input type="checkbox"/> BMI 5 – 84% (healthy weight) | <input type="checkbox"/> | <90 th (normal) | <input type="checkbox"/> |
| <input type="checkbox"/> BMI 85 – 94% (overweight) | <input type="checkbox"/> | 90-95 th (PreHT) | <input type="checkbox"/> |
| <input type="checkbox"/> BMI ≥ 95% (obese) | <input type="checkbox"/> | -99 th +5mmHg (Stage 1 HT) | <input type="checkbox"/> |
| | <input type="checkbox"/> | >99 th +5mmHg (Stage 2 HT) | <input type="checkbox"/> |

*Blood Pressure applies to Health Supervision Visits ≥3 year

NUTRITION and PHYSICAL ACTIVITY COUNSELING

5210 Information Provided

	Nutrition	Physical Activity
Discussion of current behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Pre-screening tool reviewed	<input type="checkbox"/>	<input type="checkbox"/>
Counseling or referral for related education	<input type="checkbox"/>	<input type="checkbox"/>
Person received education materials	<input type="checkbox"/>	<input type="checkbox"/>
Anticipatory Guidance	<input type="checkbox"/>	<input type="checkbox"/>

STAGE 1: PREVENTION PLUS - FOR CHILDREN WITH BMI ≥85 PERCENTILE

Review of Systems Completed Notes _____
Family and Social History Completed Notes _____
Physical Exam Completed Notes _____
Labs

Patient and/or Parent Ready for Change Yes No
(If "yes", continue. If "no" or "BMI 85-94% without risk factors", STOP)

Self-Management: Goal(s) Selected by patient/family

Nutrition

- Increase fruits/veggies per day (goal 5/d) Decrease or almost none sugar sweetened beverages
 Other _____

Physical Activity

- Limit screen time (< 2 hours/d recommended) Increase moderate to vigorous physical activity
 Other _____ (1 hour/day recommended)

Rx for Healthy Living

Nutrition and Physical Activity goal selection deferred to follow up visit

Self –Management: Circle number that represents confidence in meeting goal(s)

Not confident 0 1 2 3 4 5 6 7 8 9 10 very confident

Follow Up and/or Referral Visit Recommended (circle all that apply)

- This Practice Registered Dietitian Weight Management Clinic
 Specialist _____