Counseling the Overweight Child

Training Evaluation Form

Date: __________________ Location/Clinic: __________________

I am a: (Please check one):

_____ doctor       _____ health educator

_____ medical assistant  _____ nurse

_____ nurse practitioner  _____ nutritionist/dietitian

_____ other staff (please specify): ____________________________

1. What barriers do you encounter when you address obesity prevention?

_____ No counseling time       _____ Lack of resources or follow-up

_____ Not sure what to say       _____ Insufficient or inadequate patient education materials

_____ Too complicated       _____ Patient lack of interest

2. After this presentation, do you feel more confident in your ability to deliver obesity prevention messages during well-child exams?  

YES  NO

What increased your confidence? _________________________________

3. Was the time allowed for the presentation sufficient for you to understand the material?

_____ YES  _____ NO

Comments: ___________________________________________________

4. Did the presenter deliver the presentation in an effective manner?

_____ YES  _____ NO

What could be improved? _________________________________________

5. Would you recommend this presentation to other health care providers?

_____ YES  _____ NO

6. Other Comments /Suggestions:

___________________________________________________________________

Thank you!