Nemours®

Patient Name: _____

Date: _____

Healthy Choices Clinic Intake Packet

In developing an assessment and management plan with you that is best tailored to your child's needs, it would be helpful to learn more about your child. Thank you in advance for completing this information packet and sending it back to us prior your visit.

You can return it via facsimile at (407) 650-7255 or mail it to Healthy Choices Clinic, Nemours Children's Hospital, 13535 Nemours Parkway, Orlando, FL 32827.

Please bring a copy of this completed packet and any laboratory test information with you to your child's visit.

Today's Date: ___ / ___ / ___ Patient's Name: _____

Respondent's Name: _____

Relationship to patient: ❑ Mother ❑ Father ❑ Patient ❑ Other: _____

Primary language spoken at home: ❑ English ❑ Spanish ❑ Creole Other: _____

Do we need to arrange for a translator to assist in communication during an office visit? ❑ No ❑ Yes

Demographics

Patient's Date of Birth: ___ / ___ / ___ Sex: ❑ Female ❑ Male

Patient Race/Ethnicity (Please check all that may apply):

❑ Asian ❑ Black ❑ Hispanic/Latino ❑ Pacific Islander ❑ White ❑ Other: _____

Parents' (or other Primary Care Givers') Names:	Relationship (parent, grandparent, other)

Electronic Communications

Can we send you and/or your child electronic communications/reminders? ❑ No ❑ Yes

Patient text messaging: Mobile #: (_____) _____ - _____

Carrier: ❑ AT&T ❑ MetroPCS ❑ Sprint ❑ T-Mobile ❑ Verizon ❑ Other: _____

Patient email: _____

Parent email(s):_____

Current Concerns

When did your child's **weight** first become a concern?

❑ Infancy (< 12 months old) ❑ Toddlerhood (12 - 36 months) ❑ Preschool age (36 - 60 months)

❑ Early childhood (5 - 9 years old) ❑ Pre-teen (10 - 12 years old) ❑ Adolescence (13 - 18 years old)

How would you characterize your child's **weight gain**?

❑ Gradual over years ❑ Rapid over ____ (#) months ❑ There were cycles of weight gain & loss ❑ Other: _____

How would you describe your child's growth in **height** over the last few years?

❑ Similar to other children ❑ Slower than other children ❑ Faster than other children

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Current Concerns (Continued)

What actions have you or your child tried to manage their weight?

❑ Nothing yet ❑ Self-directed diet ❑ Nutritionist/Dietitian consultation ❑ Exercise program

❑ Commercial diet program (Weight Watchers®, Atkins®, Jenny Craig®): _____

❑ Medication: _____ ❑ Dietary/herbal supplements: _____ ❑ Surgical procedure

❑ Made herself/himself vomit ❑ Tried fasting/skipping meals ❑ Other:_____

What has worked to manage/control your child's weight?

What has **not** worked to manage/control your child's weight?

Does your child have specific **goals** around weight loss or level of activity? ❑ No ❑ Yes
If so, what does your child want to achieve?

As a parent (or other caregiver), what are **your** goals around your child's weight or activity level?

Concerning your child's weight and activity level, what worries you the most?

Weight problems commonly develop over time. Was there some specific concern or incident that is prompting you to seek help now? ❑ No ❑ Yes
If yes, please describe:

Medications

Please list any over-the-counter medications your child has taken in the last few weeks?

Please list any prescription medications (including birth control pills or hormonal therapy) taken in the last few weeks? Use back side of page for additional medications.

Please list any allergies to medications: _____

Does your child have environmental allergies, such as :

❑ Hay fever/seasonal allergies ❑ Dust ❑ Mold ❑ Other: _____

Does your child take a vitamin, mineral, herbal, or other dietary supplement (for example, protein powders)? ❑ No ❑ Yes

If so, what is the name of the supplement? _____

How much and how often is it taken? _____

Birth History

Birth weight: _____ (#) pounds _____ (#) ounces Birth length: _____ (#) inches Length of pregnancy in weeks: _____ # weeks
(Note: Nine months = 40 weeks; Premature < 38 weeks; Post mature > 40 weeks)

Delivery method: ❑ Cesarean Section ❑ Vaginal Delivery (Induced/Scheduled) ❑ Vaginal Delivery (Spontaneous)

Nourishment when an infant: ❑ Breast-fed until _____ weeks ❑ Formula ❑ Both Breast-fed & Formula

Mother had gestational diabetes during pregnancy: ❑ No ❑ Yes

Please describe any problems **during delivery** or **following** birth: _____

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Past Medical History

Has your child previously been treated for any of these medical conditions?

❑ No significant past medical history

Psychosocial concerns:
❑ Anxiety ❑ Attention Deficit/Hyperactivity Disorder (ADHD) ❑ Depression
❑ Eating disorder (Compulsive overeating, bulimia, anorexia, binge eating) ❑ Other: _____

Diabetes:
❑ Type II, insulin resistant ❑ Type I, juvenile type

Heart concerns:
❑ Heart murmur ❑ Heart problem: _____

Chest infections:
❑ Pneumonia ❑ Bronchitis

Breathing problems:
❑ Asthma ❑ Sleep apnea ❑ Other breathing problems: _____

❑ High blood pressure

❑ High cholesterol or other lipids

❑ Thyroid disease

❑ Liver/gall bladder disease

❑ Kidney problems

❑ Sleep problems (sleep apnea/sleep disordered breathing)

❑ Menstrual irregularities

❑ Heartburn/reflux

❑ Other conditions: _____

Past Surgical History

Did your child have any past surgeries and when?
❑ No past surgery ❑ Appendectomy (__ / ____) ❑ Tonsillectomy (__ / ____) ❑ Adenoidectomy (__ / ____)
❑ Ear tubes (__ / ____) ❑ Other: _____ (__ / ____)

Social History

Who lives in the household with the child? Please describe relationship (mother, father, sister, …) and their age.

What pets are at the home? ❑ Dog ❑ Cat ❑ Other: _____

Does your child regularly stay with another caregiver (e.g., grandparent)?
❑ No ❑ Yes, please describe: _____

Which of the following can be found in your child's bedroom?
❑ Television ❑ Radio ❑ Computer ❑ Video games

How is your child doing in school?
❑ Average ❑ Excelling in academics ❑ Some learning problems ❑ Other: _____

What school does your child attend? _____ Current grade in school: _____

Are there any special learning accommodations? ❑ No ❑ Yes, please describe: _____

Does your child attend an after-school or "after-care" program? ❑ No ❑ Yes, please describe: _____

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Activity History

On average, how much time each day is spent in front of a screen (television, videos, MTV, Nintendo/X-box, Internet, instant messaging/emailing, or other computer activities)?

____ (#) hours per day on average during school days
____ (#) hours per day on average during weekends or holidays

What kind of physical activity/activities does your child participate in?

How many days per week does your child participate in any physical activity
❑ None ❑_____ days/week

Please describe the activity/activities and approximate amount of time your child spends when doing the activity:

Has your child ever experienced the following during or after physical activity?
❑ Fainting (passing out) ❑ Dizziness ❑ Chest pains ❑ Trouble breathing

Eating Habits

How many days a week does your child eat breakfast? _____ (#) days/week
Does your child eat school-prepared breakfast? ❑ No ❑ Yes, if so _____ (#) days/week

How many days a week does your child eat lunch? _____ (#) days/week
Does your child eat school-prepared lunch? ❑ No ❑ Yes, if so _____ (#) days/week

How many times per week does your child eat a meal from a fast food restaurant or eat take-out food?
_____ (#) times in a week; What are your favorites? _____

How many times per week does your child join the family in eating a meal together?
_____ (#) times in a week

On a typical day, what amounts of fruits are eaten? ❑ Never ❑_____ (#) servings (1/2 cup = one serving)

On a typical day, what amounts of vegetables are eaten? ❑ Never ❑_____ (#) servings (1/2 cup = one serving)

What does your child drink for thirst? _____

How many 8 oz servings (glasses, cans, or bottles) of **regular** soda does your child drink in a typical day?
❑ None ❑_____ (#) servings in a day

How many 8 oz servings (glasses, cans, or bottles) of **fruit juice** does your child drink in a typical day?
❑ None ❑_____ (#) servings in a day

How many 8 oz servings (glasses, cans, or bottles) of **other sweetened beverages** (e.g. Gatorade®, Kool Aid®, etc.) does your child drink in a typical day?
❑ None ❑_____ (#) servings in a day

How many 8 oz servings (glasses) of the following does your child drink in a typical day?
____ (#) servings of whole milk ____ (#) servings of chocolate milk ____ (#) servings of other flavored milk
____ (#) servings of 2% (reduced fat) milk ____ (#) servings of 1% (low fat) or skim (fat free) milk

Sleep

In a typical night, does your child experience any of the following:
❑ Snoring ❑ Breathing pauses during sleep ❑ Restless sleep (frequent moving) ❑ Usually falls asleep late; what time: _____

What is your child's usual bedtime ritual (the things done prior to falling asleep?

When your child wakes up in the morning, how does your child feel?
❑ Commonly refreshed and rested ❑ Commonly awakens tired ❑ Commonly awakens with a headache ❑ Other:_____

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Daytime Sleepiness

In the following situations, what is the chance your child would doze off or fall asleep?

Please check one box per line	Never	Slight chance	Moderate chance	High chance
Sitting and reading	❑	❑	❑	❑
Watching TV	❑	❑	❑	❑
Sitting, inactive in a public place (e.g., theater or a meeting)	❑	❑	❑	❑
As passenger in a car for an hour without a break	❑	❑	❑	❑
Lying down to rest in the afternoon when circumstances permit	❑	❑	❑	❑
Sitting and talking to someone	❑	❑	❑	❑
Sitting quietly after a lunch	❑	❑	❑	❑
In a car, while stopped for a few minutes in traffic	❑	❑	❑	❑

Parents (or other primary caregiver)

Relationship	Height	Approximate Weight
(e.g., Mother)	_____ feet _____ inches	_____ pounds
(e.g., Father)	_____ feet _____ inches	_____ pounds

Family History: ❑ No family history available ❑ Adopted ❑ Foster care

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NOTE: Only blood relatives should be referenced in this section.

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	Mother	Father	Sister	Brother	Mother's side Grand-mother	Mother's side Grand-father	Father's side Grand-mother	Father's side Grand-father	Mother's side Aunt	Mother's side Uncle	Father's side Aunt	Father's side Uncle	Other (please specify)
Heart disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Hypertension	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Lipids	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Overweight/obesity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Sleep disorders	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Diabetes Type I	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Diabetes Type II	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Diabetes (type unknown)	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Kidney disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Liver/gallbladder disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Congenital hearing loss	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Anemia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Bleeding problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Sickle cell anemia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Anesthesia problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Mental illness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Learning disability	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Genetic syndrome	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Other significant family history													

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