INITIAL Healthy Habits PEDS Patient Intake Form Date: ____/___/

Patient Name: (First)_____ **(Last**_____

Date of Birth: _____/_____/_____ Gender: M / F AGE:

Parent/Guardian Name: _____.

Relationship to patient: _____.

Best Contact Phone: _____ 2nd contact phone:

Email: _____ Email may be used for communication? Yes/No

Primary Care Provider: _____.

Are there any specific QUESTIONS or EXPECTATIONS for today's visit?

Does your child feel concerned about their weight? □ YES □ NO

Around what age was your child when his/her weight became a concern?

What has been your child's highest weight, and at what weight did that occur?

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Has your child ever tried to lose weight before? □ YES □ NO

If YES, what has he/she tried? (diet/nutrition, exercise/physical activity programs, apps, websites, etc)

_____

Was your child successful? □ YES □ NO

What do you think has contributed the MOST to your child's weight gain?

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CHILD'S Past Medical History (check all that apply): □ NONE

□ Heart problem □ Gallbladder stones □ Sleep apnea □ Pre-Diabetes

□ Indigestion/reflux □ Thyroid problem □High Blood Pressure □ Diabetes

□ Kidney Problems □ High cholesterol □ Depression/Anxiety □ Polycystic Ovarian Syndrome □ Asthma □ Constipation □ Prematurity

□ Low or high birth weight

□ Developmental Delay □ Bone/Joint problems □ ADHD

□ Behavior or learning problem

□ Early puberty (female< 8 yrs, boys<9 yrs): Age of 1st menstrual cycle: □ OTHER:

Past Hospitalizations: □ None

□ _____

Past Surgeries: □ None

□_____

Past/Current Specialists: □ None

□ _____

Medications (list any current medications & dose, including over-the-counter medications, supplements, and herbs):

□ None □_____ □_____ □ .

Allergies: □ None □ To

Medications:_____

□ To Food/Other:_____

Family History (check all that apply):

Obesity or Overweight:	□ Mother	□ Father	□ Sibling	□ Grandparent –
High Cholesterol:	□ Mother	□ Father	□ Sibling	□ Grandparent –
High Blood pressure:	□ Mother	□ Father	□ Sibling	□ Grandparent –
Heart Disease (M<55,F<65):	□ Mother	□ Father	□ Sibling	□ Grandparent –
Thyroid Disease:	□ Mother	□ Father	□ Sibling	□ Grandparent –
Diabetes:	□ Mother	□ Father	□ Sibling	□ Grandparent –

Did the child's mother have diabetes during pregnancy? □Yes □No

Other family medical problems (please explain):

_____

Social History:

Please list all people who live in the child's home:

Relationship to child? (ex: mother/father)	Any Weight concerns? (Y/N)	Age	Employment/ Education

Who does the grocery shopping for the child? _____.

Who does the cooking in the home? _____.

Does the child live in more than one household? □ Yes: □No

Does an adult other than the biological parents regularly take care of this child? □Yes □No If yes, name/relationships to child? _____

Does your child have special education or accommodations at school? (IEP or 504 plan) □Yes □No

In the past 12 months, was there a time you did not have a steady place to live (including now)? □ Yes: □No

Within the past 12 months, have you worried that your food would run out before you had the money to buy more? □ Yes: □No

What type of physical activities does your child like to do?

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Which of these activities does your child do on a frequent basis?

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Number of hours of sleep your child gets per night? **Typical bedtime/wake up time:**	**9+**	**8**	**7**	**≤6**
Number of hours of screen time on weekdays?	**>3 hrs**	**2-3 hrs**	**1-2 hrs**	**<1 hr**
Number of hours of screen time on weekend?	**> 3 hrs**	**2-3 hrs**	**1-2 hrs**	**<1 hr**

What does a typical day of eating look like for your child?
Breakfast:
Lunch:
Dinner:
Snacks per day: **What types of snacks?**
Typical Drinks (milk, water, soda, Gatorade, tea, etc?)

Symptom Review (Check any symptoms that child has had **in the past 2 weeks:**)

□ Shortness of breath □ Extremely Thirsty □ Skin rash
□ Chest pain or heart racing □ Extremely Hungry □ Acne or Facial Hair
□ Passing Out or Dizzy □ Frequent urination □ Dry skin/hair
□ Cough □ Heartburn or reflux □ Joint pain (hips, knees, feet, etc)
□ Stress from Being Bullied □ Gas or bloating □ Muscle aches/pain
□ Trouble Sleeping □ Diarrhea □ Lack of energy, tired, fatigued
□ Sleeping too much □ Constipation □ Often Feels Cold
□ High Stress □ Nausea or Vomiting □ Blurry, Double vision
□ Feeling depressed or anxious □ Abdominal Pain □ Frequent Headaches
□ Poor self-esteem □ Irregular or heavy periods □ Bedwetting
□ Poor satiety: Not satisfied after eating, frequently hungry again
□ Frequent Cravings (Example: for sweets)
□ Low appetite and limited calories yet still gaining weight □ Emotional eater (Eating often due to stress, emotions)
□ Hunger above average □ Wakes up to eat at night □ Skips Meals
□ Binging/Uncontrollable eating □ Sneaks/hides food

On a scale of 1-10, with 1 being NOT ready to change at all and 10 being extremely READY to change:

How **ready** is **your child** to make changes? changes? **(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10**	How **ready** are **you (caregiver)** to make **(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10**

On a scale of 1-10, with 1 being NOT at all confident and 10 is VERY confident:

How **confident** is **your child** in their ability to change? their ability to change? **(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10**	How **confident** are you (caregiver) in **(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10**

Please explain WHY you or your child would like to lose weight or get healthier:

Please list any BARRIERS that may prevent you and your family from making lifestyle changes:

Please list and STRENGTHS that you and your child have that will help you to make healthier choices?

How will you and your child CELEBRATE success?

By signing below I acknowledge that I am ready and willing to make healthy lifestyle changes. I understand the 4 pillars of obesity medicine are nutrition, physical activity, behavioral modification and medical intervention.

Also by signing below, I agree that obesity medicine visits are purely related to obesity management. I agree that if other concerns arise during the obesity medicine visit, I will need to follow up with my primary care provider. By signing below I also agree to medical consent for treatment and all associated consent documents in the initial intake form (Your Health Information Privacy Practices, Written Acknowledgement of Receipt of NW Cypress Pediatrics and Family Medicine, PLLC Consent and Notice of Privacy Practices, General Consent to treat, Consent to treat Minor, Electronic Medical Records and Electronic Prescriptions, Office Policy, and Payment Policy).

_____ _____

Patient Name Date

_____

Guardian Signature