Children's Center for Weight Management
Initial New Patient Parent Form

Together We SHINE!

Follow below instructions to get an appointment in Children's Center for Weight Management

❑Please make sure your Primary Care Physician has faxed all paperwork to 205-212-2735. This includes Request for Specialty Clinic Form, Insurance referral (MCD referrals must be cascading with current EPSDT screening date), clinic notes, labs, parent form, and growth chart.

❑Watch the orientation video at **https://www.childrensal.org/MakingAnAppointment**. Families unable to watch the video will watch at first initial appointment.

❑Complete this form and return to: **Children's Weight Management Clinic, 1940 Elmer J. Bissell Road, Birmingham, AL 35243**

We will not schedule an appointment until PARENT FORM is received in our office. Thank you!

Initial information and lifestyle

Patient name: ____Patient age/DOB: ____________

Caregiver name/relationship ____________________________Caregiver phone: ____________

Primary language: ______________________Email:______________________________________

Patient's Gender: ❑ Male ❑ Female How motivated is family/patient? ❑Low ❑Moderate ❑ High

What are your concerns concerning your child's weight? _____________________________________

____

Has your child always had a weight problem? ❑YES ❑ NO If yes, at what age did it begin? ______
Do you or your child have expectations about the amount of weight to lose? ❑YES ❑ NO, if yes what is the amount _______lbs. over what period of time? ________months

Did you and your child watch the orientation/introduction to Weight Management clinic video? ❑YES ❑NO

BEHAVORIAL CONCERNS

Who does your child live with? __________________Are the parents ❑Married ❑Divorced ❑Separated
Does your child attend school? ❑ YES ❑ NO
What grade is your child in? ____________________
Does your child like school? ❑ YES ❑ NO
What grades does your child earn at school? ❑ A's & B's ❑ C's ❑ D's & F's
How does your child feel about him/herself? ❑ Happy ❑ Fair ❑ dislikes him/herself intensely
Does your child's weight affect how she/she feels about him/herself? ❑ YES ❑ NO
Do people treat your child differently because of his/her weight? ❑YES ❑NO ❑SOMETIMES
Is your child being teased because of his/her weight? ❑ YES ❑ NO
Is the teasing ❑ Mild ❑ Moderate ❑ Severe
Who is teasing your child? ❑ Siblings ❑ Friends ❑ Kids at school ❑ Family members ❑ teachers
❑ Other adults

PAST MEDICAL HISTORY

What was your child's birth weight? __________pounds __________ounces ❑UNKOWN
Was the pregnancy full term? ❑YES ❑NO If premature, how early? ______________________
Was the mother diabetic during pregnancy? ❑YES ❑NO ❑UNKNOWN
Was your child breast fed? ❑YES ❑NO ❑UNKNOWN How long? __________________________
Was your child formula fed? ❑YES ❑NO ❑UNKNOWN How long? __________________________
During infancy did your child have any feeding problems? ❑YES ❑NO ❑UNKNOWN
Describe feeding problem? ____ _____
Was your child overweight at age 2? ❑YES ❑NO ❑UNKNOWN
Are immunizations up to date? ❑YES ❑NO ❑UNKOWN
Describe developmental milestones (sitting, talking, walking, and independent self-care)
❑NORMAL ❑DELAYED
Has your child ever been hospitalized? ❑YES ❑NO If yes, what age? ___ And reason? __________
____
Has your child ever had surgery? ❑YES ❑NO If yes, what age? And reason? ___________________
____

Other relevant information: ____

FAMIY MEDICAL HISTORY-Do or did any family members have any of the following health conditions or medical procedures?

Health Condition	Mother	Father	Maternal Grandparent	Paternal Grandparent	Maternal Aunt/Uncle	Paternal Aunt/Uncle
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Cholesterol or Triglycerides	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Heart Attack before age 50	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Overweight or Obesity	☐	☐	☐	☐	☐	☐
Gastric Bypass	☐	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐
Polycystic Ovary Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐

Areas of Most Concern (check all that apply)

❑Rate of Weight Gain
❑Elevated Body Mass Index (BMI)
❑Family history (describe below)
❑Liver
❑Lipids/Cholesterol
❑Blood Pressure/Hypertension
❑Mood (depression, anxiety, family stressors, eating disorder)
❑Diabetes
❑Irregular menses
❑Polycystic ovaries
❑Joint Problems
❑Sleep/OSA
❑Other ____
____

Family is most interested in

❑Nutritional counseling
❑Physical Activities
❑Laboratory testing
❑Bariatric surgery
❑Psychological services
❑Group activities

History of Present Condition (HPI)

Is your child having abdominal pain? ❑YES ❑NO

If yes, what is the abdominal pain like? ❑Burning ❑Constant ❑Cramping/spasms ❑Dull ❑Stabbing/sharp

How does your child describe the pain? ❑No hurt ❑a little bit hurt ❑a little bit more hurt ❑even more hurt ❑hurts a lot ❑hurts as much as possible

Is your child having problems with swallowing? ❑YES ❑NO

Is your child having pain with swallowing? ❑YES ❑NO

Does your child have problems with nausea? ❑YES ❑NO

Does your child have problems with diarrhea? ❑YES ❑NO

Is your child constipated? ❑YES ❑NO

Is your child having pain associated with constipation? ❑YES ❑NO

Is your child having chest pain? ❑YES ❑NO

What is the pain like? ❑Burning❑Constant ❑Cramping/spasms ❑Dull ❑Stabbing/sharp ❑Radiating

How would you describe the chest pain? ❑No hurt ❑A little hurt ❑more hurt ❑even more hurt ❑hurts a whole lot ❑hurts as much as possible

Where is the chest pain? ❑Right side ❑left side ❑back

Is pain associated with? ❑Rest ❑mild exercise ❑heavy exercise

Does your child have shortness of breath?❑YES❑NO

If yes, it is associated with?❑Rest ❑mild exercise ❑heavy exercise

Does your child sleep on pillows or in a chair because of shortness of breath? ❑YES ❑NO

Does your child sit up during the night because of shortness of breath? ❑YES ❑NO

Does your child have swelling of the feet or abdomen? ❑YES ❑NO

Does your child have heart palpitations? ❑YES ❑NO

Does your child have headaches? ❑YES ❑NO

If yes, what is the location? ❑Top of head ❑right side of head ❑Left side of head ❑back of head ❑Neck/shoulders ❑face ❑eyes

Describe the severity of the headaches? ❑Mild ❑moderate ❑severe

Does your child have pain/swelling in joints? ❑YES ❑NO If yes, what is the location? _____________

Is your child sleepy during the daytime? ❑YES ❑NO Does your child snore at night? ❑YES ❑NO

Does your child have hypertension? ❑YES ❑NO Is it controlled by medication? ❑YES ❑NO

Does your child have Type 2 Diabetes? ❑YES ❑NO Does your child have Type 1 DM? ❑YES❑NO

Does your child have respiratory problems or asthma? ❑YES ❑NO Describe the severity? ❑Mild ❑moderate ❑severe

Does your child have skin rashes? ❑YES ❑NO

If yes, what is the location of the skin rash? ❑Face/neck ❑arms/hands ❑trunk ❑skin fold ❑legs/feet

Is your child experiencing excessive hairiness? ❑YES ❑NO

Does your child have purple or blue lines in or on skin? ❑YES ❑NO

Has your daughter had her first menstrual period? ❑YES ❑NO if yes, at what age? ___

How would you describe her periods? ❑Regular ❑Lack of ❑Infrequent ❑Frequent, more than once a month ❑currently pregnant

List any other medical problems: ____

____

____

____

ACTIVITY/INACTIVITY

Is your child? ❑ Very active ❑ somewhat active ❑ Inactive ❑ Very inactive ❑ don't know

Does your child have any physical limitations, if so explain?

____

____

On a scale of 1 to 10, with 1=least active and 10+ most intense, please rate the physical intensity of your child's exercise 1 2 3 4 5 6 7 8 9 10

On an average week how many days did your child participate in organized sports (**NOT** including P.E.?
①②③④⑤

Does your child have a TV in his/her bedroom? ❑ YES ❑ NO

Does your child have a computer? ❑ YES ❑ NO

How many hours per day does your child watch TV during the weekdays? ❑ <1hr ❑ 1-2 hrs ❑ 3-4 hrs ❑ 5+ hrs

How many hours per day does your child watch TV during the weekends? ❑ <1hr ❑ 1-2 hrs ❑ 3-4 hrs ❑ 5+ hrs

How many hours per day does your child use the computer during weekdays? ❑ <1hr ❑ 1-2 hrs ❑ 3-4 hrs ❑ 5+ hrs

How many hours per day does your child use the computer during weekends? ❑ <1hr ❑ 1-2 hrs ❑ 3-4 hrs ❑ 5+ hrs

What activities does your child enjoy?

____

NUTRITION

How would you describe your child's appetite? ❑ Picky ❑ Variable ❑ Good ❑ Excellent

Does your child eat second helpings? ❑YES❑ NO

What size portions does your child eat? ❑ Small ❑ Medium ❑ Large

How fast does your child eat? ❑Slowly ❑ Average ❑ Quickly

Does your child crave sweets? ❑YES ❑ NO Does your child hide food? ❑ YES ❑ NO

Does your child eat when depressed or anxious? ❑ YES ❑ NO

Does your child sneak food? ❑ YES ❑ NO

In the last week, how often did your child eat something from a fast food restaurant? ①②③④⑤

Does your child drink sugar sweetened beverages? ❑ YES ❑ NO

Does your child drink fruit juices? ❑YES ❑NO

Does your child eat low fat meats? ❑YES ❑ NO

Does your child eat 100% whole grain breads? ❑YES ❑ NO

Does your child add butter/margarine to foods? ❑ YES ❑ NO

Does your child add salt to foods? ❑YES ❑NO

What condiments does your child use regularly (e.g. mayo, ranch dressing, ketchup)?

____

What type of milk does your child drink? ❑ Whole ❑ 2% ❑ Chocolate ❑ 1% ❑ Skim/nonfat ❑ doesn't drink milk

What type of oil does the family use to cook with? ❑Canola ❑ Corn ❑ Olive ❑ Vegetable ❑ Other