Shine Clinic
(Children's Center for Weight Management Clinic)
Initial New Patient Parent Form

Children's of Alabama

Follow below instructions to get an appointment in Shine Clinic Appointment:

- ❑ 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, and growth chart.
- ❑ If child is under age 4, only complete sections 1, 3, 4, and 5.
- ❑ Watch the clinic introduction video at ***https://www.childrensal.org/weight-management***

- ❑ Please complete this form and mail to:
  Por favor complete el formulario y envíe por correo a:

  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 ***(SECTION 1)***

Patient name: _____Patient age/DOB: _____

Caregiver name/relationship _____Caregiver phone: _____
What is a permanent number where we can reach you? _____
Primary language _____Email: _____
Patient's Gender: ❑ Male ❑ Female How motivated is family/patient? ❑Low ❑Moderate ❑ High
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

Areas of Most Concern (check all that apply) ***(SECTION 2)***

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

Family is most interested in

❑Nutritional counseling
❑Physical Activities
❑Laboratory testing
❑Counseling

PAST MEDICAL HISTORY ***(SECTION 3)***

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 At what age did your child start gaining weight? _____ Are immunizations up to date? ❑YES ❑NO ❑UNKOWN
Describe developmental milestones (sitting, talking, walking, etc.) ❑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? _____
Does your child have any medical/psychiatric/emotional problems? ❑ YES ❑ NO If yes, please describe_____

FAMIY MEDICAL HISTORY-Do/did any family members have any of the following health conditions or medical procedures?
(SECTION 3 CON'T)

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	☐	☐	☐	☐	☐	☐
Healthy	☐	☐	☐	☐	☐	☐

Social History (Section 4)

Who lives in the home with your child? _____

Does your child attend school? ❑ YES ❑ NO Homeschooled? ❑ 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

Are there any barriers to keep you from bringing your child to clinic? ❑ work ❑ transportation ❑ sibling needs ❑ financial

Within the past 12 months have you worried about whether your food would run out before you got money to buy more? ❑ YES ❑ NO

Within the past 12 months did you find the food you bought just didn't last and we didn't have money to get more? ❑ YES ❑ NO

Review of Systems (HPI) (section 5)

General: Does your child seem to have low energy? ❑YES ❑NO Is your child in good health? ❑YES ❑NO

HEENT: Wears glasses? ❑YES ❑NO

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

Review of Systems (HPI) ***(SECTION 5) cont.***

CV: 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 swelling of the feet or abdomen? ❑YES ❑NO
Does your child have heart palpitations? ❑YES ❑NO
Does your child have hypertension? ❑YES ❑NO Is it controlled by medication? ❑YES ❑NO

Respiratory: Does your child have respiratory problems or asthma? ❑YES ❑NO Describe the severity? ❑Mild ❑moderate ❑severe
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 snore at night? ❑YES ❑NO
Are there pauses or gasps with the snoring? ❑YES ❑NO

GI: 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
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

Neuro: 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

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

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

Sleep: What time does your child go to sleep? ___ What time does he/she get up? ___ Is he/she easy to wake up? ❑YES ❑NO Does he/she fall asleep in school? ❑YES ❑NO Is your child sleepy during the daytime? ❑YES ❑NO Takes naps? ❑YES ❑NO Does your child have his/her own sleeping space and mattress?

Skin: 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

GU/Reproductive: Does your child have pain with urination? ❑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 Last Menstrual period? _____

Review of Systems (HPI) ***(SECTION 5) cont.***

List any other medical problems: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ACTIVITY/INACTIVITY ***(SECTION 6)***

Do you feel your child is? ❑ Very active ❑ somewhat active ❑ Inactive ❑ Very inactive ❑ don't know
Does your child have any physical limitations, if so explain? _____

If your child does activities or exercises, please rate the physical intensity of your child's exercise on a scale of 1 to 10, with 1=least active and 10+ most intense, 1 2 3 4 5 6 7 8 9 10
On an average week how many days did your child participate in organized sports or activities (**NOT** including P.E.)? ①②③④⑤

Does your child have a TV, computer, tablet, or cell phone in his/her bedroom? ❑ YES ❑ NO
How many hours per day does your child spend with these devices during the weekdays? ❑ <1hr ❑ 1-2 hrs. ❑ 3-4 hrs. ❑ 5+ hrs.
How many hours per day does your child spend with these devices during the weekends? ❑ <1hr ❑ 1-2 hrs. ❑ 3-4 hrs. ❑ 5+ hrs.

NUTRITION ***(SECTION 7)***

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 many minutes does it take your child eat? _____
Does your child crave sweets? ❑YES ❑ NO
Does your child eat when depressed or anxious? ❑ YES ❑ NO
Does your child sneak/hide 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
What condiments does your child use regularly (e.g. mayo, ranch dressing, ketchup, BBQ sauce)?
_____
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
What have you tried for weight loss? _____ What worked? _____ What didn't work?
_____