

## New Patient Questionnaire Parent Form

- Please make sure your Primary Care Physician has faxed all paperwork to 314-577-5364 including referral, clinic notes, labs, and growth chart.
- Please complete this form and return it to our office.
  - Mail:** Healthy First Weight Management, Desloge Tower 7094  
1465 S. Grand Blvd., St. Louis MO 63104
  - Fax:** 314-577-5335
  - Email:** [cgbariatrics@ssmhealth.com](mailto:cgbariatrics@ssmhealth.com)
- We will not schedule an appointment until Parent Form is received in our office.**

### Initial information and lifestyle

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Caregiver name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you the legal guardian? \_\_\_\_\_ If not, who is? \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Child's gender:  Male  Female  I prefer not to answer

Do you or your child have expectation about the amount of weight to lose?

Yes  No If yes, what is your expectation? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What have you tried for weight loss? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Past Medical History

Child's birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.  Unknown

Was the pregnancy full term?  Yes  No If premature, how early? \_\_\_\_\_

Was the mother diabetic during pregnancy?  Yes  No  Unknown

During infancy did your child have any feeding problems?  Yes  No

Describe feeding problem: \_\_\_\_\_

\_\_\_\_\_

Was your child overweight at age 2?  Yes  No  Unsure

At what age did your child's weight become a concern? \_\_\_\_\_

\_\_\_\_\_

Who has expressed a concern for your child's weight? \_\_\_\_\_

\_\_\_\_\_

Did your child hit developmental milestones (sitting, talking, walking, etc) on time?  Yes  Delayed

If delayed, please describe: \_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_ What surgery? \_\_\_\_\_

\_\_\_\_\_

Does your child have any medical/psychiatric/emotional problems?  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Please list current medications that your child is taking: \_\_\_\_\_

\_\_\_\_\_

In your opinion, what factors are causing your child to have excess weight? \_\_\_\_\_

\_\_\_\_\_

Has your child had any big life events/stressors? \_\_\_\_\_

\_\_\_\_\_

## Family Medical History

Do/did any family members have any of the following health conditions or medical procedures?

Health condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling
Diabetes							
Heart disease							
High cholesterol							
Cancer							
Heart attack before age 50							
High blood pressure							
Overweight/obesity							
Bariatric surgery							
Gallstones							
Thyroid disease							
Polycystic ovary disease							
Stroke							
Bleeding disorders/DVT							
Liver disease							
Mental health issues							
Healthy							

## Review of Systems

Does your child experience the following?

	Yes	No		Yes	No
Shortness of breath			Feels cold (when everyone else feels warm)		
High blood pressure			Abnormal, excessive hair growth		
Snoring			Excessive tiredness		
Joint pain or swelling			Darkened skin on neck/armpits		
Recurrent constipation			Bluish purple lines in skin		
Recurrent belly pain			Frequent headaches		
Acid reflux			Wakes up often at night to urinate		
Frequent nausea/vomiting			Bedwetting		
Limping			Irregular menses		

List any other medical problems: \_\_\_\_\_

\_\_\_\_\_

## Social History

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?  As and Bs  Cs  Ds and Fs

How does your child feel about themselves? \_\_\_\_\_

Does your child's weight affect how they feel about themselves?  Yes  No

Do people treat your child differently because of their weight?  Yes  No  Sometimes

Is your child being teased/bullied because of their weight?  Yes  No

Is the teasing?  Mild  Moderate  Severe

Who is teasing/bullying your child?

Sibling  Friends  Kids at school  Teachers  Family members  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 didn't have money to get more?

Yes  No

Does anyone smoke or vape inside or outside the house?  Yes  No

## Activity

How often does your child get physical activity? Please check off how many minutes per day and how many times per week your child does any exercise/physical activity (please include time they spend in PE/physical education class).

How many minutes per day?	How many days per week?	How many days per week does your child have a PE class?
<input type="checkbox"/> 5-10 minutes per day	<input type="checkbox"/> 7 days per week	<input type="checkbox"/> 0 days 1 day 2 days
<input type="checkbox"/> 10-20 minutes per day	<input type="checkbox"/> 5-6 days per week	<input type="checkbox"/> 3 days 4 days 5 days
<input type="checkbox"/> 20-30 minutes per day	<input type="checkbox"/> 3-4 days per week	
<input type="checkbox"/> 30-40 minutes per day	<input type="checkbox"/> 1-2 days per week	How many days per week does your child have recess?
<input type="checkbox"/> 40-50 minutes per day	<input type="checkbox"/> None	<input type="checkbox"/> 0 days 1 day 2 days
<input type="checkbox"/> 50-60 minutes per day		<input type="checkbox"/> 3 days 4 days 5 days

## Activity (continued)

What types of physical activity does your child engage in? \_\_\_\_\_

On average, how many days per week are you physically active as a family (parent/caregiver and child)?

None

3-4 days

Daily

1-2 days

5-6 days

Is your neighborhood safe for a child to play outside?  Yes  No

## Sleep/Screen time

On average, what time does your child fall asleep during the weeknights/school nights?

11pm or later

9 pm

7 pm

10 pm

8 pm

On average, what time does your child usually wake up on weekday mornings/school days?

9 am or later

7 pm

5 am

8 am

6 am

Does your child wake up in the middle of the night?  Yes  No

If yes, how many times does your child wake up in the middle of the night?

5 times or more per night

2 times per night

4 times per night

1 time per night

3 times per night

Does your child feel rested when waking in up in the morning?  Yes  No

How often does your child nap and for how long?

Daily

4 or more hours

1 hour

1-2 times per week

3 hours

30 minutes

2-3 times per week

2 hours

15 minutes

Only on weekends

Does your child fall asleep using screens (TV, computer/tablet, cell phone, etc)?  Yes  No  Sometimes

How many hours a day does your child have screen time (TV, computer/tablet, cellphone, video games)?

Less than 1 hour/day  1-2 hours/day  3-4 hours/day  5+ hours/day

## Body Image

Please rate how often your child is concerned or does the following:

My Child	Always	Often	Sometimes	Never
Is preoccupied with hiding and disguising their body				
Is concerned about social interactions because of their weight				
Has strong dissatisfaction with their body				
Believes they would be happy if they were thin				
Avoids social situations because of their physical appearance				
Makes negative statements about their body				

### Nutrition

(Note: Questions generally relate to your child's behaviors over the past 3-4 months.)

How often does your child eat three meals a day?

<input type="checkbox"/> 7 days a week	<input type="checkbox"/> 3 days a week
<input type="checkbox"/> 6 days a week	<input type="checkbox"/> 2 days a week
<input type="checkbox"/> 5 days a week	<input type="checkbox"/> 1 day a week
<input type="checkbox"/> 4 days a week	

Estimate your child's intake of soft drinks, sodas (regular/diet), fruit drinks, sports drinks, and energy drinks. A serving size is 8 ounces for drinks.

<input type="checkbox"/> 6 or more servings per day	<input type="checkbox"/> 2 servings per day
<input type="checkbox"/> 5 servings per day	<input type="checkbox"/> 1 serving per day
<input type="checkbox"/> 4 servings per day	<input type="checkbox"/> 0 servings per day
<input type="checkbox"/> 3 servings per day	

Estimate the average number of fist-sized servings of vegetables that your child eats each day. (Do not include french fries in your count.)

<input type="checkbox"/> 6 or more servings per day	<input type="checkbox"/> 2 servings per day
<input type="checkbox"/> 5 servings per day	<input type="checkbox"/> 1 servings per day
<input type="checkbox"/> 4 servings per day	<input type="checkbox"/> 0 servings per day
<input type="checkbox"/> 3 servings per day	

Estimate the average number of fist-size or whole-piece servings of fruits your child eats each day. (Do not count fruit juice for this question.)

<input type="checkbox"/> 6 or more servings per day	<input type="checkbox"/> 2 servings per day
<input type="checkbox"/> 5 servings per day	<input type="checkbox"/> 1 servings per day
<input type="checkbox"/> 4 servings per day	<input type="checkbox"/> 0 servings per day
<input type="checkbox"/> 3 servings per day	

## Body Image (continued)

Estimate the amount of milk and dairy products your child eats each day. This includes yogurt, milk (8 oz), cheese (1 oz).  
**Circle type of milk: whole, 2%, 1%, fat-free, soy/almond milk.**

3 or more servings per day

1 serving per day

2 servings per day

0 servings per day

Consider the number of times your child ate fast food, take out, or restaurant food over the last three months.

5 or more times per week

2 servings per week

4 servings per week

1 serving per week

3 servings per week

No fast food

Estimate how many 8 ounce servings of water your child drinks on an average/typical day.

8 or more servings per day

3 servings per day

6-7 servings per day

2 servings per day

5 servings per day

1 serving per day

4 servings per day

0 servings per day

How many days per week does your child consume/eat fried foods?  
(examples: fried fish, fried chicken, fried cheese sticks, french fries, etc.)

Most days (5-7 days)    Some days (3-4 days)    Rarely (0-1 days)

How often does your child snack?    Most days    Some days    Rarely

Does your child get hungry often? \_\_\_\_\_

Do you eat meals as a family? \_\_\_\_\_

Where does your child usually eat their meals? \_\_\_\_\_

How do you feel about your child's nutrition? \_\_\_\_\_

\_\_\_\_\_

## Emotional/Behavioral Eating

Does your child experience a loss of control with food?    Yes    No

Does your child sneak food?    Yes    No   If yes how often? \_\_\_\_\_

Does your child eat food late at night/wakes up from sleep to eat?    Yes    No   If yes how often? \_\_\_\_\_

Does your child ever eat extremely large amounts of food, in a short period of time, where they do not seem to be able to stop eating despite feeling uncomfortably full (binge eating)?    Yes    No

## Emotional/Behavioral Eating (continued)

If yes, how many times a week does this occur?

5+ more times weekly  3-4 times weekly  1-2 times weekly

Does your child express feelings of guilt and shame after engaging in such eating patterns?  Yes  No

Does your child ever fast (refuse to eat), exercise excessively, use laxatives, or vomit after bingeing?

No  Yes (check which behavior(s))  Fasting  Excessive exercising  Use of laxatives  Vomiting

Without bingeing, does your child ever fast (refuse to eat), exercise excessively, use laxatives, or vomit after bingeing?

No  Yes (check which behavior(s))  Fasting  Excessive exercising  Use of laxatives  Vomiting

## Motivation for Change

How motivated is family/child?  Low  Moderate  High

Child's current motivation for nutrition behavior changes (check one)?

1-Not Motivated  2- Slightly Motivated  3- Motivated  4-Very Motivated  5-Extremely Motivated

Child's current motivation for physical activity behavior changes (check one)?

1-Not Motivated  2-Slightly Motivated  3- Motivated  4-Very Motivated  5-Extremely Motivated

Child's current motivation for participation in the program (check one)?

1-Not Motivated  2- Slightly Motivated  3- Motivated  4-Very Motivated  5-Extremely Motivated

Strengths for Lifestyle change: \_\_\_\_\_

Barriers for Lifestyle change: \_\_\_\_\_

The Healthy First Program's mission focuses on learning lifelong habits to support nutrition and movement the entire family can enjoy. Small changes can make a big difference in the life of our patients and their families.

The program consists of an in depth first appointment, monthly dietician only appointments, and follow up appointments with the multidisciplinary team. The multidisciplinary team consists of a pediatrician, nurse practitioners, registered dietitians, a social worker, and a psychologist.

During the first appointment your family will meet with providers from our multidisciplinary team. This visit lasts approximately 2 hours and includes a program introduction, a nutrition assessment and counseling, a complete medical history and physical exam, and a psychological evaluation. The patient and family will return to clinic every 3-4 months to revisit goals and review any medical issues. The Healthy First Program supports families who are interested in exploring habits that promote health.

Thank you for completing our New Patient Form. Someone from our team will reach out to confirm your enrollment.

Please call our office with any questions or concerns at **314-577-5335**.

