

**HEALTHY FUTURES**

**MEDICAL AND HEALTH HISTORY**

**PARENT/GUARDIAN PLEASE COMPLETE PRIOR TO VISIT**

**PATIENT AND FAMILY INFORMATION**

**Today’s Date:** **Child’s Name:**

**Date of Birth:** **Social Security Number:**  **Gender: M or F**

**Name of person completing form:**  **E-mail:**

1. **Form completed by:**
* Biological mother
* Biological father
* Step-mother
* Step-father
* Maternal grandmother
* Maternal grandfather
* Paternal grandmother
* Paternal grandfather
* Foster mother
* Foster father
* Adoptive mother
* Adoptive father
* Child
* Other: \_\_\_\_\_\_\_\_\_ \_
1. **Child’s ethnicity**
* Hispanic or Latino
* Non-Hispanic
1. **Child’s race (check all that apply)**
* American Indian or Alaska Native
* Asian American
* Black/African American
* Native Hawaiian or Pacific Islander
* White/Caucasian
* Other \_\_\_\_\_\_
1. **Average household income before taxes**
* Less than 10,000
* 10,000 - 19,999
* 20,000 - 29,999
* 50,000 - 59,999
* 60,000 - 69,999
* Above 70,000
* 30,000 - 39,999
* 40,000 - 49,999
* Prefer not to answer
1. **How many people (in your household or otherwise) are supported by the income indicated above? \_\_\_\_\_\_\_\_\_\_**
2. **Is this income adequate to cover your monthly expenses?**
* No
* Sometimes
* Usually
* Yes
1. **What is the highest level of education attained in the household?**
* Less than high school
* High school diploma or GED
* Some college
* Undergraduate degree
* Graduate degree
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT AND FAMILY HOME LIFE**

1. **Are your child’s biological parents**
* Married
* Divorced
* Separated
* Other \_\_\_\_\_\_\_\_\_\_
1. **Who does your child live with? (Check all that apply)**
* Both parents together
* Both parents separately
* Mother only
* Father only
* Stepmother
* Stepfather
* Maternal grandparent
* Paternal grandparent
* Aunt
* Uncle
* Sibling
* Foster parent(s)
* Adoptive parent (s)
* Other: \_\_\_\_\_\_\_\_\_\_
1. **Does your child live or spend an extended amount of time with a relative in a different home?**
* Yes
* No
	+ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **Please list the name, gender and age of your child’s siblings.**

|  |  |  |
| --- | --- | --- |
| Name | Gender | Age |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Does anyone in your household smoke (inside or outside)?**
* Yes
* No
1. **Have any of these events occurred to anyone in your household over the *past year*? (Check all that apply)**
* Marriage
* Divorce
* Money problems
* Birth
* Death
* Change of job
* Break-up
* Change of school
* Chronic illness
* Serious injury
* Legal problems
* Move
* DHS Involvement
* None
1. **Please list any other recent or current stressful experiences:**

**PATIENT ACADEMIC HISTORY**

1. **What grade is your child in school?**
2. **What is the name of your child’s school?**
3. **During the past 6 months, how would you describe your child’s grades?**
* Excellent (mostly A’s)
* Above average (mostly B’s)
* Average (mostly C’s)
* Failing

(mostly D’s and F’s)

1. **Over the past 6 months, would you say your child has experienced any academic problems/dropping grades?**
* Yes
* No
* I don’t know
1. **Over the past 6 months, would you say your child has developed any behavioral problems at school?**
* Yes
* No
* I don’t know
1. **Over the past 6 months, would you say your child has developed any learning problems at school?**
* Yes
* No
* I don’t know
1. **Over the past 6 months, has your child been suspended or expelled from school?**
* Yes
* No
* I don’t know
1. **Over the past 6 months, would you say your child has developed any problems with their peers at school?**
* Yes
* No
* I don’t know
1. **Does your child have an Individualized Education Plan (IEP) or Section 504 Plan?**
* Yes
* No
* I don’t know
1. **In school, does your child participate in special education classes or have any resource services/accommodations?**
* Yes
* No
* I don’t know
1. **In a typical month, how often does your child miss school?**
* 0-1 day
* 2-4 days
* 5 or more days

**CONCERNS ABOUT WEIGHT**

1. **How concerned are you about your child’s weight? (Circle the best answer)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | A little | Somewhat | A lot | Very much |
| 1 | 2 | 3 | 4 | 5 |

1. **Please rate the following types of concerns about your child’s weight.**

**(Circle the number from 1 to 5 that best represents your level of concern)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Not at all | A little | Somewhat | A lot | Very much |
| Current health issues | 1 | 2 | 3 | 4 | 5 |
| Future health issues | 1 | 2 | 3 | 4 | 5 |
| Teasing | 1 | 2 | 3 | 4 | 5 |
| Low self esteem | 1 | 2 | 3 | 4 | 5 |
| Unable to be active | 1 | 2 | 3 | 4 | 5 |
| Clothes don’t fit | 1 | 2 | 3 | 4 | 5 |
| Other concerns | 1 | 2 | 3 | 4 | 5 |

1. **In your opinion, what contributes to your child’s excessive weight?**
* Eating too much
* Eating unhealthy foods
* Stress
* Emotional eating
* Not enough exercise
* Too much TV/videogames
* Genetics (it runs in the family)
* Life event
* Hormone Problem
* Other \_\_\_\_\_\_\_\_\_
1. **Has your child always had a problem with his/her weight?**
* Yes
* No
* If no, at what age did your child’s weight become a problem?
1. **Has your child ever tried to lose weight?**
* Yes
* No
* If yes, how many pounds did your child lose?
1. **If your child did lose weight, how long was the weight loss maintained?**
* 1 month
* 2- 6 months
* 7-12 months
* More than 1 year
1. **Has your child ever worked with any of the following for the purposes of weight loss?**
* Registered Dietitian
* Cardiologist
* G.I. doctor
* Endocrinologist
* Kidney doctor
* Physical Therapist
* Psychologist
* Psychiatrist
* Personal Trainer
* Weight loss program, (Weight Watchers, Jenny Craig, etc.)
* None
1. **To your knowledge, has your child ever tried any of the following as a means of weight loss?**
* Laxatives
* Diuretics
* Fasting
* Diet pills
* Vomiting
* Prescription medications
* None
1. **What do you think has kept you and/or your child from making changes in his/her eating habits? (Check all that apply)**
* Not interested
* Financial concerns
* Need more information to make these changes
* Too much stress with family and school
* No need for change
1. **What do you think has kept you and/or your child from making changes in his/her physical activity? (Check all that apply)**
* Not interested
* Financial concerns
* Did not want to spend the time
* Need more information to makes these changes
* Too much stress
* Don’t like to exercise
* No need for change
1. **What do you expect the Healthy Futures clinic can or will do for your child?**

**(Check all that apply)**

* Perform lab testing
* Give a diet prescription
* Give an activity prescription
* Prescribe medication
* Discuss surgery
* I don’t know

**BIRTH HISTORY**

1. **What was your child’s birth weight?** \_\_\_\_\_\_\_ pounds \_\_\_\_\_\_\_ounces \_\_\_\_\_unknown
2. **What was your child’s birth length?** \_\_\_\_\_\_\_ inches \_\_\_\_\_unknown
3. **Was the pregnancy full term?**
* Yes
* No
* Unknown
* If your baby was premature, how early?
1. **Were there any complications during pregnancy or delivery with your child?**
* No
* Diabetes
* Vomiting to control weight
* High blood pressure
* Too little weight gain
* Binge eating
* Too much weight gain
* Other\_\_\_\_\_\_\_\_\_\_\_
1. **Did your child have any medical problems as a newborn? (Check all that apply)**
* None
* Infection
* Jaundice
* Breathing problems
* Floppy muscles
* Poor growth
* Feeding problems
* Other \_\_\_\_\_\_\_\_\_\_
1. **Was your child breastfed?**
* Yes
* No
* Unknown
* If yes, number of months
1. **Was your child formula fed?**
* Yes
* No
* Unknown
* If yes, number of months name of formula
1. **At what age did your child start eating solid foods? (Including rice cereal)**
* < 4 months
* 4-5 months
* 6-8 months
* 9-12 months
* > 1 year
* Unknown

**MEDICAL HISTORY**

1. **How would you describe your child’s developmental milestones (sitting, talking, walking and independent self-care)?**
* Normal
* Delayed
1. **Hospitalization History: Please list any prior hospitalizations (require overnight stay).**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Age | Approximate Date | Reason | Name of Hospital |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Surgical History: Please list any prior surgeries and approximate dates.**

|  |  |  |
| --- | --- | --- |
| Child’s Age | Approximate Date | Surgery Performed  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Does your child have any allergies (food, medication, environmental etc.)?**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **Please list any prescription medications that your child is currently taking.**
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
15. **Has your child ever taken, or is your child currently taking:**
* Steroids
* Seizure medications
* Cholesterol lowering medications
* Thyroid medications
* Behavioral medications
1. **Please list any over the counter medications (supplements, vitamins, minerals, herbs, nutritional) that your child is currently taking.**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **Patient Medical History:**

**Please check the best answer for each question.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medical Problem | Never | In the Past | Now | Unknown |
| Abnormal menses |  |  |  |  |
| ADHD/ADD/hyperactivity |  |  |  |  |
| Alcohol or drug abuse/treatment |  |  |  |  |
| Anorexia |  |  |  |  |
| Anxiety |  |  |  |  |
| Asthma |  |  |  |  |
| Binge eating |  |  |  |  |
| Depression |  |  |  |  |
| Diabetes (type 1) |  |  |  |  |
| Diabetes (type 2) |  |  |  |  |
| Experienced or witnessed a traumatic event |  |  |  |  |
| Gallstones |  |  |  |  |
| Gastroesophageal reflux |  |  |  |  |
| Heart problems |  |  |  |  |
| High blood pressure |  |  |  |  |
| High cholesterol |  |  |  |  |
| Joint problem |  |  |  |  |
| Kidney problem |  |  |  |  |
| Mental health or psychiatric illness |  |  |  |  |
| Liver problem |  |  |  |  |
| Physical abuse |  |  |  |  |
| Polycystic ovary syndrome |  |  |  |  |
| Sexual abuse |  |  |  |  |
| Sexually active |  |  |  |  |
| Sleep apnea |  |  |  |  |
| Vomiting to control weight |  |  |  |  |
| Other medical problem |  |  |  |  |

1. **Family Medical History:**

**Please indicate with a (**√**) family members who have had any of the following conditions:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Health Condition | Mother | Father | Maternal Grandparent | Paternal Grandparent | Maternal Aunt/Uncle | Paternal Aunt/Uncle | None | Unknown |
| Sudden death |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |
| Heart disease |  |  |  |  |  |  |  |  |
| Type 2 diabetes |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |
| Thyroid disease |  |  |  |  |  |  |  |  |
| High cholesterol |  |  |  |  |  |  |  |  |
| High triglycerides |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |
| Gastricbypass |  |  |  |  |  |  |  |  |
| Gallstones |  |  |  |  |  |  |  |  |
| Polycystic ovary disease |  |  |  |  |  |  |  |  |
| Mental health |  |  |  |  |  |  |  |  |
| Alcohol or drug abuse/ treatment |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |

1. **Family Medical Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Members** | **Current Age** | **Current Height** | **Current Weight** | **Unknown** |
| Biological mother  |  |  |  |  |
| Biological father  |  |  |  |  |
| Sibling  |  |  |  |  |
| Sibling  |  |  |  |  |

1. **Review of Systems:**

**Does your child currently have any of the following problems?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Problem** | **Yes** | **No** | **Unknown** |
| Blurry vision |  |  |  |
| Nasal congestion/allergies  |  |  |  |
| Dental carries/cavities  |  |  |  |
| Eczema (skin allergy) |  |  |  |
| Headaches  |  |  |  |
| Snoring  |  |  |  |
| Sleep apnea (pauses in breathing during sleep) |  |  |  |
| Daytime sleepiness |  |  |  |
| Acne  |  |  |  |
| Excessive hair growth  |  |  |  |
| Darkening of the skin on neck, under the arms or around the waist  |  |  |  |
| Breast enlargement (apart from normal development)  |  |  |  |
| Irregular menstrual periods  |  |  |  |
| Frequent urination  |  |  |  |
| Increased thirst  |  |  |  |
| Sudden weight loss/weight gain  |  |  |  |
| Always hungry  |  |  |  |
| Chest pain  |  |  |  |
| Ankle swelling  |  |  |  |
| Shortness of breath  |  |  |  |
| Cough  |  |  |  |
| Wheeze  |  |  |  |
| Vomiting  |  |  |  |
| Diarrhea  |  |  |  |
| Constipation  |  |  |  |
| Stomach pain  |  |  |  |
| Urinary tract infections  |  |  |  |
| Bedwetting  |  |  |  |
| Nocturia (waking up at night to use the bathroom) |  |  |  |
| Daytime leakage of urine  |  |  |  |
| Back pain  |  |  |  |
| Hip pain  |  |  |  |
| Knee pain  |  |  |  |
| Behavioral problem/anxiety/depression  |  |  |  |

**NUTRITION AND PHYSICAL ACTIVITY INFORMATION**

1. **The food our family bought last month was not enough, and we didn’t have enough money to buy more?**
* Yes
* No
* Don’t know
1. **In the last 12 months, my family worried whether our food would run out before we got money to buy more?**
* Yes
* No
* Don’t know
1. **On a scale of 1-10, with 1 being “not confident at all” and 10 being “very confident”, what is your confidence in following a recipe?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5=Sort of confident

 10= Very confident

1. **On a scale of 1-10, with 1 being “not confident at all” and 10 being “very confident”, what is your confidence in preparing a home-cooked meal?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5=Sort of confident

 10= Very confident

1. **In a typical week, how many meals were frozen?**
* 0-1
* 2
* 3
* 4
* 5
* 6
* 7 or more
1. **What types of sugar sweetened beverages are in the home?**
* Juice
* Soda
* Chocolate milk
* Gatorade/Powerade
* Sweet tea
* Koolaid/Lemonade
1. **How many days of the week do you exercise?**
* 0
* 1
* 2
* 3
* 4
* 5
* 6
* 7

**HEALTH AND BEHAVIOR INFORMATION**

1. **On a 1-10 scale with 1 being “not important at all” and 10 being “most important,” how would you rate the *importance* of changing your *child’s health*?**

1 2 3 4 5 6 7 8 9 10

1=Not important at all

 5=Sort of important

 10= The most important

1. **On a scale of 1-10 with 1 being “not confident at all” and 10 being “most confident,” how would you rate your *confidence* in changing your *child’s health*?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5= Sort of confident

 10= The most confident

1. **On a 1-10 scale with 1 being “not important at all” and 10 being “most important,” how would you rate the *importance* of changing your child’s *eating habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not important at all

 5= Sort of important

 10= The most important

1. **On a scale of 1-10 with 1 being “not confident at all” and 10 being “most confident,” how would you rate your *confidence* in changing your child’s *eating habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5=Sort of confident

 10= The most confident

1. **On a 1-10 scale with 1 being “not important at all” and 10 being “most important,” how would you rate the *importance* of changing your child’s *physical activity habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not important at all

 5=Sort of important

 10=The most important

1. **On a scale of 1-10 with 1 being “not confident at all” and 10 being “most confident,” how would you rate your *confidence* in changing your child’s *physical activity habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all 5=Sort of confident 10= The most confident

**PHYSICAL ACTIVITY INFORMATION**

**ATTENTION PARENT/GUARDIAN, IF YOUR CHILD IS 12YRS OF AGE OR OLDER, PLEASE HAVE THEM FILL OUT THE REST OF THIS FORM**

1. **I would describe myself as**
* Very Active
* Somewhat Active
* Inactive
* Very Active
* I don’t Know
1. **Compared to my friends, I am**
* More Active
* Less Active
* About the same
* I don’t know
1. **Do you feel like you are able to do physical activity or exercise?**
* Yes, very much so
* Yes, somewhat
* Not really, I get easily tired
* No, not at all
* I don’t know
1. **On a typical day, for how many minutes do you participate in physical activity or exercise?**
* 0-29 minutes
* 30-59 minutes
* 60-89 minutes
* 90 minutes or more
1. **Does anything prevent you from being physically active? For example, does any part of your body hurt when you are active?**
2. \_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_
8. **On a scale of 1-10, please rate the typical intensity of your exercise.**

 1 2 3 4 5 6 7 8 9 10

1= Comfortable pace can do this all day, not sweating or breathing hard

5= A little uncomfortable and sweating, but can still talk easily

10=Sweating a lot, breathing very heavy, cannot continue

1. **What do you do after school or daycare?**
* Snack
* Watch TV
* Use the computer
* Play outside
* Videogames
* Homework
* Play inside
* Chores
* Work
1. **In an average week, when you are in school, how many days do you take a physical education (PE) class?**
* 1
* 2
* 3
* 4
* 5
1. **In the past 7 days, how many days did you exercise or participate in physical activity for at least 20 minutes that made your heart beat fast or made you breathe hard, such as basketball, baseball, softball, swimming, gymnastics, track, football, dance, tennis or marching band?**
* 0
* 1
* 2
* 3
* 4
* 5
* 6
* 7
1. **Over the past 12 months, did you take part in any organized physical activities (such as a team sport), or take lessons such as karate, dance, gymnastics or tennis?**
* Yes
* No
1. **What types of resources do you have at home to help with physical activity? Check all that you have.**
	* Bike
	* Roller blades
	* Skateboards
	* Yoga balls
* Weights
	+ Nintendo Wii
	+ Basketball/soccer ball
	+ Nearby park
	+ Other:\_\_\_\_\_\_\_\_\_\_
1. **What community resources are available to you and your family?**
	* YMCA
	* Recreation Center or gym
	* Nearby Park
	* Other:\_\_\_\_\_\_\_\_\_\_\_
2. **How many days of the week do your parent/guardians exercise?**
* 0
* 1
* 2
* 3
* 4
* 5
* 6
* 7
1. **Do you have a TV in your bedroom?**
* Yes
* No
1. **On a typical weekday, how many hours of screen time do you get? Screen time includes: TV, computer, tablet, phone or video games.**
* I don’t have any screen time
* Less than 1 hour
* 1-2 hours
* 3-4 hours
* More than 4 hours
1. **On a typical weekend day, how many hours of screen time do you get? Screen time includes: TV, computer, tablet, phone, video games.**
* I don’t have any screen time
* Less than 1 hour
* 1-2 hours
* 3-4 hours
* More than 4 hours
1. **What activities do you enjoy doing?**
* Bowling
* Dancing
* Go to the park
* Karate/martial arts
* Basketball
* Football
* Soccer
* Ride a bike
* Rollerblading
* Running
* Swimming
* Walking
* Walk the dog
* Other \_\_\_\_\_\_\_\_\_\_

**NUTRITION INFORMATION**

1. **How would you describe your eating habits? (Check all that apply)**
* I am a picky eater (I do not like a lot of foods/certain food groups)
* I am good eater (not picky, I eat from all food groups)
* I am always hungry/never satisfied
* I “graze” on food, or eat throughout the day rather than at planned meals/snacks
1. **On average, how many meals do you eat per day?**
* 1
* 2
* 3
* 4 or more
1. **On average, how many snacks do you eat per day?**
* 0-1
* 2
* 3
* 4 or more
1. **Do you typically eat the lunch that is provided by the school, or bring your lunch from home?**
* Most of the time I eat the lunch prepared by the school
* Most of the time I bring lunch from home
* Combination of both
1. **At home, where do you eat most of your meals?**
* At the kitchen/dining room table
* In front of the television, tablet, phone
* Bedroom
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **On a scale of 1-10, with 1 being “not confident at all” and 10 being “very confident”, what is your confidence in following a recipe?**

1 2 3 4 5 6 7 8 9 10

 1=Not confident at all

 5=Sort of confident

 10= Very confident

1. **On a scale of 1-10, with 1 being “not confident at all” and 10 being “very confident”, what is your confidence in preparing a home-cooked meal? (not frozen meal)**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5=Sort of confident

 10= Very confident

1. **In a typical week, how many days did you eat at least one meal as a family? (at home or elsewhere)**
* 0
* 1
* 2
* 3
* 4
* 5
* 6
* 7 or more
1. **How many days in a typical week do you or someone in your home prepare or cook the food you eat?**
* 0-1
* 2
* 3
* 4
* 5
* 6
* 7 or more
1. **In a typical week, how many meals were frozen?**
* 0-1
* 2
* 3
* 4
* 5
* 6
* 7 or more
1. **In a typical week, how many meals do you eat food from places other than the home?**
2. **Convenience Store (gas station, corner store)**
* 0-1
* 2
* 3
* 4
* 5
* 6
* 7 or more
1. **Restaurant/Fast food (pick up or sit down)**
* 0-1
* 2
* 3
* 4
* 5
* 6
* 7 or more
1. **At home, who typically does the grocery shopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **At home, who typically prepares the meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Do you typically eat second helpings?**
* Yes
* No
* Sometimes
1. **Are there any foods you cannot stop eating once you’ve started?**
* Yes
* No
* I don’t know
1. **Do you ever feel negative feelings after eating, such as shame, embarrassment, disgust, depression, or guilt?**
* Yes
* No
* I don’t know
1. **In a typical week, how many days did you eat breakfast?**
* 0
* 1
* 2
* 3
* 4
* 5
* 6
* 7
1. **How would you describe the speed at which you eat?**
* Slow
* Average
* Fast
1. **Do you ever hide food?**
* Yes
* No
* I don’t know
1. **Do you ever sneak food when no one is looking?**
* Yes
* No
* I don’t know
1. **Do you ever eat for reasons other than being hungry?**
* Nervous
* Sad/upset/lonely
* Bored
* Happy
* Mad
* Other \_\_\_\_\_\_\_\_\_\_
* No, I only eat when I am hungry
1. **On a typical day, how many servings of fruit do you eat?**

***A serving is about the size of your fist (1 medium piece of fruit or ½ cup).***

* 0 servings
* 1 serving
* 2 servings
* 3 or more servings
1. **On a typical day, how many servings of vegetables do you eat?**

***A serving is about the size of your fist (1 medium vegetable, 1 cup of leafy greens or ½ cup of cooked vegetables).***

* 0 servings
* 1 serving
* 2 servings
* 3 or more servings
1. **On a typical day, how much milk do you drink?**
* \_\_\_\_\_\_child size cups
* \_\_\_\_\_\_ adult size cups
* \_\_\_\_\_\_individual cartons
1. **What type of milk do you typically drink? (Check all that apply)**
* Whole/Vitamin D
* 2%
* 1%
* Skim/nonfat
* Full fat chocolate
* Low fat chocolate
* Skim/nonfat chocolate
* Soy/almond/rice
* I don’t know
* I don’t drink milk
1. **Thinking about the grains that you eat (bread, rice, pasta, hamburger buns, tortillas, pizza crust etc.), would you say that they are mostly white in color or dark brown in color?**
* White
* Dark brown
* I don’t know
1. **On a typical day, how many servings of whole grains (dark brown) do you eat? *A serving is 1 slice of bread, 1 small tortilla, 1 cup of breakfast cereal and ½ cup of noodles or rice.***
* 0-3 servings
* 3-6 servings
* 6-9 servings
* 9 or more servings
1. **On a typical day, how many servings of refined grains (white) do you eat? *A serving is 1 slice of bread, 1 small tortilla, 1 cup of breakfast cereal and ½ cup of noodles or rice.***
* 0-3 servings
* 3-6 servings
* 6-9 servings
* 9 or more servings
1. **On a typical day, how many cups of water do you drink?**
* 0 cups
* 1-3 cups
* 4-6 cups
* 7 or more cups
1. **Do you drink any sugar sweetened beverages such as sweet tea, soda/pop, juice, Kool-Aid, or Gatorade?**
* Yes
* No
1. **On a typical day, I drink:**
* Juice? \_\_\_\_\_ cups
* Soda? \_\_\_\_\_ cups/cans/bottles (circle one)
* Diet Soda? \_\_\_\_\_ cups/cans/bottles (circle one)
* Chocolate Milk? \_\_\_\_\_ cups/cartons (circle one)
* Powerade/Gatorade? \_\_\_\_\_ cups/bottles (circle one)
* Sweet Tea? \_\_\_\_\_ cups/bottles (circle one)
* Kool Aid/Lemonade? \_\_\_\_\_ cups/bottles (circle one)
* Energy Drinks? \_\_\_\_\_ can/bottles (circle one)

**SLEEP HYGIENE INFORMATION**

1. **Check the most appropriate number for each situation:**

0=would never doze or sleep

1=slight chance of dozing or sleeping

2=moderate chance of dozing or sleeping

3=high chance of dozing or sleeping.

* 1. **Sitting and reading**
		+ 0
		+ 1
		+ 2
		+ 3
	2. **Watching television**
		+ 0
		+ 1
		+ 2
		+ 3
	3. **Sitting inactive in a public place (for example, a movie theater or classroom)**
		+ 0
		+ 1
		+ 2
		+ 3
	4. **As a passenger in a car for an hour without a break**
		+ 0
		+ 1
		+ 2
		+ 3
	5. **Lying down to rest in the afternoon when circumstances permit**
		+ 0
		+ 1
		+ 2
		+ 3
	6. **Sitting and talking to someone**
		+ 0
		+ 1
		+ 2
		+ 3
	7. **Sitting quietly after lunch**
		+ 0
		+ 1
		+ 2
		+ 3
	8. **Doing homework or taking a test**
		+ 0
		+ 1
		+ 2
		+ 3
1. **Do you take a nap?**
* Yes
* No

 **If so, what time?**  **For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **On a regular basis, do you: (check all that apply)**
	* Snore
	* Stop breathing during sleep
	* Gasp in sleep
	* Sleep walk
	* Sleep talk
	* Grind teeth
2. **When is your usual bedtime on weekdays?** **(am/pm)**
3. **When is your usual bedtime on weekends? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_ **\_(am/pm)**
4. **What time do you usually wake for the day on weekdays? \_\_\_\_\_\_** **(am/pm)**
5. **What time do you usually wake for the day on weekends? \_\_\_\_\_\_** **(am/pm)**
6. **On average, how long does it take for you to fall asleep?**
7. **Do you wake up during the night? If so, on average, how many times?**
	* I do not wake up
	* 1 time
	* 2-5 times
	* Greater than 5 times

**HEALTH AND BEHAVIOR INFORMATION**

1. **On a scale of 1-10, with 1 being “not important at all” and 10 being “most important,” how would you rate the *importance* of changing your *health*?**

1 2 3 4 5 6 7 8 9 10

1=Not important at all

 5=Sort of important

 10= The most important

1. **On a scale of 1-10, with 1 being “not confident at all” and 10 being “most confident,” how would you rate your *confidence* in changing your *health*?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5= Sort of confident

 10= Very Confident

1. **On a scale of 1-10, with 1 being “not important at all” and 10 being “most important,” how would you rate the *importance* of changing your *eating habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not important at all

 5= Sort of important

 10= The most important

1. **On a scale of 1-10 with 1 being “not confident at all” and 10 being “most confident,” how would you rate your *confidence* in changing your *eating habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5=Sort of confident

 10=Very confident

1. **On a scale of 1-10, with 1 being “not important at all” and 10 being “most important,” how would you rate the *importance* of changing your *physical activity habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not important at all

 5=Sort of important

 10=The most important

1. **On a scale of 1-10 with 1 being “not confident at all” and 10 being “most confident,” how would you rate your *confidence* in changing your *physical activity habits*?**

1 2 3 4 5 6 7 8 9 10

1=Not confident at all

 5=Sort of confident

 10=Very confident

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Child Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_