UCLA Health System

REGISTRATION FORM

UCLA Fit for Healthy Weight Program
www.fitprogram.ucla.edu **Name:**
Fax: 310-825-4640 **Date:**

Note: Please write legibly in black ink. The first two pages of this form should be filled out primarily by a parent. The remainder of the form should be filled out by the patient with parental assistance depending on age and situation. Include additional pages as needed.

PARENT SECTION

BIRTH HISTORY

Birth Weight?_____ Term of Pregnancy (if known): Full Term / Premature (_____weeks)
Maternal Complications (maternal diabetes, hypertension, preeclampsia, twins)?_____
Birth Complications?_____No. of Months Breastfed? _____

PAST MEDICAL & SURGICAL HISTORY (hospitalizations, illnesses, surgeries, accidents):

FAMILY HISTORY (Check or list all medical problems and weight for all family members and for all other individuals living in the patient's home.)

	Weight (lb/kg)	Lives in patient's home?	Age Now (or at death)	Over-weight	Heart Disease	Diabetes	High Blood Pressure	Other: CANCER, Depression, Stroke, Bleeding, Clotting, Liver, Gallstones, etc.
Father								
Mother								
Other:								
Brothers:								
Sisters:								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								

REVIEW of SYMPTOMS (Circle all that apply to the patient. His/her input may be required)

CONSTITUTIONAL	**ENDOCRINE**	**GASTROINTESTINAL**	**MUSCULOSKELETAL**
Fever	Often thirsty	Heartburn/regurgitation	Back pain
Night sweats	Often urinating	Stomach pain	Hip pain
Chills	Thyroid enlargement	Diarrhea	Knee pain
Loss of weight	Heat/cold intolerance	Constipation	Ankle/Foot pain
Gain of weight	Osteoporosis	Gas	Other pain
Weakness	Elevated blood sugar	Nausea	Muscle pain/weakness
SKIN	Insulin Resistance	Vomiting	Broken bones
Rash	**RESPIRATORY**	Difficulty swallowing	Bow Legs
Hives	Wheezing	Hemorrhoids	Club foot
Itching	Persistent coughing	Rectal bleeding	**IMMUNO/ALLERGIC**
Dryness	Shortness of breath	Yellow skin/eyes	Persistent infections
Birthmarks	Sleep apnea	Lack of stool control	HIV exposure
BREAST/CHEST	Other	Gallstones	Food Allergies
Lumps	**CARDIOVASCULAR**	Hepatitis	**PSYCHIATRIC**
Swelling	Chest pain	Fatty liver	Anxiety/Nervousness
Tenderness	High blood pressure	Dark stools	Day/Night Wetting
EYES	Low blood pressure	H.pylori/Ulcers	Depression/Suicide
Eye infections	Difficulty breathing	**GENITO-URINARY**	Hyperactivity
Visual Changes	Rapid heart beat	Frequent urination	Aggression
Crossed eyes	Swelling arms/legs	Leak urine with cough	Non-compliant
ENMT	Pale or blue lips/skin	Blood in urine	Habits/Tics
Ear Infections	Elevated cholesterol	Pain with urination	**MALES**
Difficulty hearing	Elevated lipids	Lack of bladder control	Lump in testicles
Nosebleed	**HEME/LYMPH**	Bulging in groin	Penis discharge/sore
Snoring	Swollen glands	**NEURO**	**FEMALES**
Sinus problems	Anemia	Headache	Vaginal discharge
Bleeding gums	Sickle cell	Convulsions	Menstrual pain
Difficult to swallow	Easy bruising	Paralysis	Abnormal bleeding
Hoarseness	Abnormal bleeding	Numbness	Last menstrual period___
Mouth breathing	Blood transfusions	Dizziness	Birth-control pills

MEDICATIONS (Include Over the Counter Medications)

Medication	Amount	# per Day	Medication	Amount	# per Day

ALLERGIES

Medication/Food Allergies & Reaction	Medication/Food Allergies & Reaction

PATIENT SECTION (Parental assistance may be required)

GENERAL

How did you hear about this program?

What do you think of your weight now?

What do you hope to achieve with the UCLA FIT for Healthy Weight Program?

How long have you been overweight? _____
How much do you weigh now? _____
What is your goal weight? _____
How long do you think it will take for you to achieve your goal? _____

Have you tried other weight-loss programs (e.g. Weight Watchers, Jenny Craig)? Which ones? When? For how long? What worked best? Why did you stop?

Have you successfully lost weight in the past? If yes, how much?

How ready are you to make the changes necessary to lose weight (0 to 5 – not ready to very ready)? _____
How ready are your parent(s)/guardian(s) ready to help you make these changes (0 to 5 – not ready to very ready)? Name_____ #____ Name_____ #____

Have you considered weight-loss surgery?

Do you have a friend or family member who has had weight-loss surgery? Who? Why?

HOME INFORMATION

Does one (or both) of your parents live somewhere other than with you?

What are the methods of discipline used in your house (for example, grounding or taking away privileges)?

Do you help care for older relatives or other family members? How often?

Do you help care for your younger siblings? How often?

Do you have pets?

What language/s do you usually speak at home?
What language do you speak at school?
What is your parents' primary language?
Do you have a job? How many hours a week do you work?
Do you have children? How many?

SCHOOL

What grade are you in?
What school do you go to?
What are your favorite and least favorite subjects in school?
What grades do you usually get (As, Bs, Cs, other)?
Have you ever repeated a grade?
Do you miss/skip/cut any classes?
What do you do after school?
How would you describe your friends?
Do you have a best friend?
Have you been in trouble with the police?
What do you want to be when you grow up?

ACTIVITY

What hobbies do you have that are important to you?
How do you get to school (walk, bike, bus, or car)?
How far away is your school?
Do you have physical education at school?
  If yes, how often and what activities?
Do you have recess at school?
  If yes, how often and what activities?
Do you belong to any sporting teams?
  If yes, how many times per week do you practice?
Outside of school, what activities/exercise do you perform?
  How many hours per day?
What is the *most strenuous* physical activity that you do in a week?

How many hours a day do you watch TV on a weekday? Weekend?
How many hours a day do you play video games on a weekday? Weekend?
How many hours a day do you spend on the computer on a weekday? Weekend?

How far can you go before you must stop to rest? No. of blocks ___ No. of flights___

If you do stop to rest, why? _short of breath _ tired _ pain (where?_____) _ other

Are there any parks in your neighborhood?

Is it safe to go to the park during the day or early evening?

What prevents you from being more active (check all that apply)?

- ☐ I'm self-conscious about my looks.
- ☐ I'm not interested in physical activity.
- ☐ I don't have enough self-discipline or willpower.
- ☐ I don't have anyone to do physical activities with me.
- ☐ I don't have enough money to do the activities I like.
- ☐ I'm too overweight to be physically active.
- ☐ I don't enjoy physical activity.
- ☐ I don't have the right equipment (e.g., ball, racquet).
- ☐ The weather is too bad to exercise.
- ☐ I have don't the skills for physical activity.
- ☐ I don't know how to do physical activities.
- ☐ I don't have a convenient place for physical activity.
- ☐ Other:
- ☐ I'm in poor health.
- ☐ I'm afraid I'll injure myself.
- ☐ Physical activity is hard work
- ☐ Physical activity is boring.
- ☐ I hate to fail.
- ☐ I have minor aches and pains.
- ☐ I don't have enough time to be active.
- ☐ I have to work too much.
- ☐ I have too many social demands.
- ☐ I have too many family demands.
- ☐ I'm too tired to exercise.
- ☐ I don't have enough energy.

DIET

How many carbonated beverages (soda drinks like Coke) do you drink a day?

Diet or regular? How big of a serving?

How many Slurpies or other sweetened-drinks do you drink a day?

How much juice do you drink a day? What kind of juice?

How much water do you drink a day?

How much milk do you drink a day? Skim / 1% / 2% / whole.

How many coffee drinks do you have per day?

Decaffeinated/Regular? Cream, whole or low-fat milk?

What meals do you eat at school?

If applicable, what does your school cafeteria offer and what food items do you usually choose?

Do you snack at school? If yes, describe:

Are there vending machines at school? If yes, what do you find in them?

How many meals a day do you eat at home?

How many meals a day do you eat away from home?

Do you have breakfast?

Who does the food shopping in your household?

Who does the cooking in your household?

What is typically cooked?

How many of those dinners are TV/frozen dinners?

How many dinners are cooked at home each week?

How often do you eat fast-food or take-out for dinner?

How often do you eat in front of the TV?

How often do you eat at the dinner table with the TV off?

How often do you eat at a sit-down restaurant?

With whom do you eat meals (no one, family, friends)?

Do you like sweets (candy, cake, soft drinks)?

Do you like carbohydrates (fries, pasta, bread, rice, potatoes, crackers)?

What is your food 'weakness' (e.g. Cheetos, chocolate, cereal, cake, coke)?

Do you snack at home? If yes, describe.

Do you snack out of habit or boredom?

Do you 'binge' eat? ('Binge' means that you eat a lot of food all at once and feel a little 'out of control' while you are doing it).

Do you eat in the middle of the night?

How many calories do you think you eat a day?

Why do you think that you are overweight? (Check all that apply)
__ Low Metabolism __ Eat Too Much __ Eat Sweet/Snacks

Have you used any of the following to control your weight?
Y / N Bingeing & Vomiting
Y / N Bingeing (followed by food restriction)
Y / N Bingeing (followed by excessive exercise)
Y / N Medications
Y / N Vomiting Alone (without Bingeing)
Y / N Diuretics
Y / N Laxatives

What prevents you from having a better diet?
□ I don't have enough self-discipline or will-power.
□ I don't have anyone to eat healthy with me.
□ I don't like to eat healthy foods.
□ I don't have enough money to eat healthy food.
□ I don't have the right kitchen to cook healthy food.
□ I don't know how to read nutrition labels.
□ There is too much junk food around the house.
□ Other:
□ Dieting is hard work.
□ Healthy foods are boring.
□ I hate to fail.
□ I don't have enough time to cook.
□ I have to work too much.
□ I don't know how to eat healthy.
□ My family is too tired to cook.

OTHER

Have any major events happened in your life (e.g., move, divorce, death, friendship, boy/girl-friend)?

Have you considered doing harm to yourself? Have you ever thought about suicide?

Has anyone in your family been depressed or attempted suicide?

Do you ever feel sad, 'down,' or anxious?

What do you do when you are feeling sad, 'down,' or anxious? Is there someone you talk to?

Do you or your family members drink alcohol?

Do you or your family members smoke cigarettes?

Do you or your family members use drugs?

How many hours do you sleep per night on the weekdays? Weekends? Nap?

What is your greatest fear regarding a weight-loss program?

What is your greatest hope regarding a weight-loss program?

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation. (0 – would *never* doze 1 – *slight* chance of dozing 2 – *moderate* chance of dozing 3 - *high* chance of dozing)

Sitting and reading	___
Watching television	___
Sitting inactive in a public place (e.g. theater)	___
As a passenger in a car for an hour without break	___
Lying down to rest in the afternoon when circumstances permit	___
Sitting and talking to someone	___
Sitting quietly after a lunch without alcohol	___
In a car, while stopped for a few minutes in the traffic	___

TOTAL SCORE (Add the number of above to get total). ____
(What does your score mean? 1 to 6 Good Sleep; 7 to 8 Average; 9-24 Very sleepy).

FOOD & ACTIVITY DIARY (Write down EVERYTHING that you eat & all activities during the course of 1 week. Include extra pages as needed. *See example in italics*).

DATE	TIME	FOODS/SNACKS or ACTIVITY (Quantity or Distance/Time)	LOCATION
3/8/08 Sa	*7am*	*Cereal with 1% Milk (2cups) & Orange Juice (1cup)*	*Home*
	8am	*Walk (2miles/20min)*	*To a friend's home*

DATE	TIME	FOODS/SNACKS or ACTIVITY (Quantity or Distance/Time)	LOCATION

YOUR PHYSICIANS Include the name, address, phone number, and fax number of your physicians including primary care doctor, endocrinologist, gastroenterologist, pulmonologist, surgeon, and/or psychologist (if applicable).

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURES Date:_____

Patient _____Phone (___)_____E-mail_____

Parent/Guardian _____Phone (___)_____E-mail_____

Parent/Guardian _____Phone (___)_____E-mail_____

OFFICE USE ONLY

Reviewing Physician: *Date:*
Psychologist: *Date:*
Dietitian: *Date:*
Physical Therapist: *Date:*

Fax/Mail COMPLETED Registration Form along with a copy of your insurance card and authorization (if applicable).

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