Label

Last Name, First Name

Med Rec #_____ or

Date of Birth_____

Mt. Washington Pediatric Hospital

Weigh Smart Jr. Program

New Patient Preschool Information Form

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596
*(410) 578-5342 ♦ **FAX:** (410)578-2654*

PLEASE OBTAIN A COPY OF YOUR CHILD'S GROWTH CHART FROM YOUR PRIMARY CARE PHYSICIAN AND ATTACH TO THIS FORM. RETURN ALL FORMS TO THE ABOVE ADDRESS

Today's Date: **11/10/09**

Name of person completing the form and relationship to child: **Katherine Jacobs, Mother**
Do you have custody of child: (Yes) No If not, who does: _____
Patient Name: **Julia Jacobs**
Date of Birth: **2/22/04** Age: **5** Current Weight: **95** Ht:**4'0**
Patient Ethnicity: (Please note: for informational purposes and is optional) **PLEASE CIRCLE**

0-Caucasian
(1-African American)
2-Hispanic
3-Asian
4-Other_____

Address: **76 East Bottom Road, Baltimore, MD 21213**
Telephone: Home: **410-321-1234**
E-mail Address: **KJacobs@gmail.com**
Parent's name: **Julia Jacobs** Work Telephone: **410-123-3213**
Referring Physician: **Dr. Smith** Phone: **410-888-5555**
Why are you interested in our program: **To help my child lose weight and feel better**

BIRTH HISTORY:

Weight: **7lb 10oz** **Length: 19 2/3 inches** Full Term: (**Yes**) **No** Premature: **Yes** (**No**)

Which hospital? **Union Memorial Hospital**

How long was he or she hospitalized? **3 days**

If premature, at what week was child born:_____

Please describe:

Problems during pregnancy: Yes (No) _____
Problems during delivery: Yes (No) _____
Problems in the first month: Yes (No) _____

FEEDING HISTORY:

Breast fed: (Yes) No

If yes, how long: **3 months** and if yes please circle one: **Pumped** or (**Nursed**)

What infant formulas were used: **soy formula**

At what age were rice cereal and baby foods introduced: **4 months**

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What foods do you avoid giving to your child: _____

Is there a history of feeding disorders: Yes (No)

If yes, what kind: _____

What is your major concern about your child's feeding?

Hungry too often

Has your child ever had any problem with the following?

Choking?	____ Yes	___√___ No
Gagging?	____ Yes	___√___ No

If vomiting is a problem, when does vomiting occur?

During feeding?	____ Yes	√____ No
After feeding?	____ Yes	____ No
Unrelated to feeding?	____ Yes	____ No
When upset?	____ Yes	____ No

How often does vomiting occur?

____ Times per day
____ Times per week
____ Times per month
√____ Occasionally

How often does your child have a bowel movement?

____ Times per day
____ Times per week
____ Times per month
√____ Occasionally

Are stools usually

a. (Watery)
b. Formed
c. Pasty
d. Runny

EATING STYLE:

Does your child eat large meals: (Yes) No

Likes to nibble: (Yes) No

Skips meal: Yes (No) (if yes, which meal or meals, please circle):

Breakfast Lunch Dinner

Who grocery shops: **PLEASE CIRCLE ALL THAT APPLY**

(0-Mother) 1-Father

2-Both Parents 3-Grandparent

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4-Child 5-Child and Parent
6-Child and Grandparent

Who prepares the meals: **PLEASE CIRCLE ALL THAT APPLY**

(0-Mother) 1-Father
2-Both Parents 3-Grandparent
4-Child 5-Child and Parent
6-Child and Grandparent

Number of fast food meals/week: **3**_____

Which restaurant(s): **McDonalds, Fridays, Taco Bell**_____

How many meals eaten outside the home/ week: **2**_____ Where: **Fast food places**_____

Does the child eat school breakfast or meals at daycare/pre-school? YES or (NO)

School lunch? (YES) or NO

Favorite foods: **Hotdogs, Pizza, Chicken Nuggets**_____

Favorite drinks: **Coke, Juice**_____

Eats at the table with family: Always Never (Sometimes)

Eats in front of television: Always Never (Sometimes)

Does not eat much but has tendency to gain weight: Yes (No)

Is your child particular about certain foods: Yes (No)

If yes, to which ones: _____

Have you previously tried diets to help your child lose weight: Yes (No)

If yes, which one(s): _____

Is your child on a special diet: Yes (No)

If yes, which one(s): _____

Does family eat between meals: (Yes) No

What is eaten for snacks frequently (at least once a week): (please circle:

(0-Cookies/Cakes) 3-Sandwiches 6-Yogurt
1- Fresh Fruit (whole fruit, not juice) 4-Granola 7-Nuts
(2-Chips) 5-Cereal (8-Candy)

_____

What time of day is the child most hungry: **PLEASE CIRCLE ALL THAT APPLY**

0-Morning
(1-Afternoon)
2-Evening
3-Late Night

How many times a day does the child say she or he is hungry: **0 – 1 – 2 – 3 – (4) – 5 – More**

Does the child eat before going to bed: (Yes) No

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If yes, what is eaten: **icecream, cookies**

What does your child usually choose to drink: **PLEASE CIRCLE ALL THAT APPLY:**

(0-Soda) how much per day (ounces or cups): **5 cups**

(1-Juice) how much per day (ounces or cups): **24 oz**

2-Water how much per day (ounces or cups):_____

3-Milk how much per day (ounces or cups):_____

What kind? Whole 2% 1% Skim

4-Other: _____

Is food hidden or eaten in secret by family members:

Yes (No) Who:_____

Is there a history of eating disorders in the family: (Yes) No

If yes, please explain: **overeating**

Have any contributed to your child's weight problems: **CIRCLE ALL THAT APPLY**

(0-Boredom)
1-Stress
2-Anger
3-Happiness
(4-Sadness)
5-Food as Reward
6-Portions
(7-Eating Out)
8-Snacking
(9-Holidays)
10-No Activity
11-Genetics
12-Lack of Planning
13-Smell/Sight of Food

What kind /type of food does your child eat and how frequently does he/she eat it? (Use the following as a guide: never = 0 times per week, seldom = 1-2 times per week, occasionally = 3=4 times per week, always = daily).

Food Type	*Never*	*Seldom*	*Occasionally*	*Always*
Fruit: bananas, oranges, peaches,etc.		**X**		
Fruit Juice				**X**
Cereal			**X**	
Bread/toast				**X**
Starches/grains: muffins, donuts, pasta, crackers, pretzels, rice, etc.				**X**
Combination foods: lasagna, macaroni & cheese, soup, pizza, etc.				**X**
Fats: butter, oil, mayo, etc.			**X**	
Sweets: cookies, candy, cake, etc.				**X**
Milk/Dairy: ice cream, pudding, yogurt, cheese, etc.		**X**		
Eggs		**X**		
Meat (red)			**X**	
Chicken		**X**		

Pork	**X**			
Fish	**X**			
Green veggies		**X**		
Yellow veggies	**X**			
Kool-aid/punch				**X**
Tea	**X**			
Soda				**X**
Lemonade			**X**	

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What problem(s) does your child have with feeding?
(Check all that apply)

√ Eats too fast	___ Eats too little	√ Messy eater
___ Eats too slow	√ Eats too much	___ Plays with food
___ Does not chew	___ Pushes food away	___ Leaves table
___ Eats non-food items	___ Sneaks food	___ Picky eater
___ Spits food out	___ Refuses to open mouth	___ Drools
√ Throws/drops food	√ Takes food from others	___ Ruminates
___ Cries or tantrums	___ Refuses to swallow food	___ Vomits/gags
___ Turns away from spoon		

Other _____

Do you use any of these feeding techniques with your child to get him/her to eat?

___ Coax	___ Distract with toys	___ Limit foods
√ Threaten	___ Change meal schedule	___ Spank
√ Offer reward	___ Mini-meals	___ Force feed
___ Ignore	___ Praise	√ Use television
√ Send to room/time out	___ Change foods offered	

Other _____

Where do you feed your child?

___ Lap
___ Infant seat
___ High chair (regular_____adapted_____)
___ Booster seat
√ Table/chair
___ Modified chair (e.g., wheelchair, tumbleform chair, etc)
___ Stand/roam
___ Floor
___ Couch
Other_____

Does your child self-feed?	√ Yes	___ No
Using hands?	___ Yes	√ No
Using utensils?	√ Yes	___ No
Is it hard for you to tell if your child is hungry?	___ Yes	√ No
Does your child have a predictable feeding schedule?	√ Yes	___ No
Does your child's food intake vary much from		
Meal to meal?	___ Yes	√ No
Day to day?	___ Yes	√ No
Is child likely to eat more at one meal than other meals?	√ Yes	___ No

If so, which meal and why? **Dinner because she is always hungry after school**

Does your child eat better for one caregiver or the other?	___ Yes	√ No

If yes, please specify the individual:_____

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Does your child refuse to touch certain food or objects?

√ Yes _____ No

Does your child object to certain smells? √ Yes _____ No

How long does the feeding take?

√ Less than 15 minutes
_____ 15-30 minutes
_____ 30-60 minutes
_____ More than 60 minutes

Does your child understand commands? √ Yes _____ No

How does you child communicate?

Verbal	√ Yes	_____ No
Non-verbal	_____ Yes	_____ No
Gestural	_____ Yes	_____ No
Electronic device	_____ Yes	_____ No

Does your child communicate food preferences? √ Yes _____ No

Does your child sleep through the night? √ Yes _____ No

If not, why?_____

Do you have any concerns about your child's development? _____ Yes √ No

If yes, explain._____

PAST MEDICAL HISTORY:

What childhood illnesses have your child been treated for: _____

Has your child ever been hospitalized: Yes (No), please list: _____

Has your child ever had surgery: Yes (No), please list: _____

Has your child had any accidents: Yes (No), please list: _____

Has your child had any special medical treatments for a medical condition: Yes (No)

If yes, please list: _____

IMMUNIZATIONS AND ALLERGIES:

Are Immunizations up to date? (Yes) No

FAMILY HISTORY:

Who lives in the home with your child? **Mother, Father, Sister**

Who is involved in your child's care? **Mother, Father**

Biological Parents:

Mother: Age: **33** Ht: **5'5** Current Wt: **170** Most you've weighed: **180**

Father: Age: **37** Ht: **5'11** Current Wt: **240** Most you've weighed: **245**

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Siblings:	Age	Ht.	Wt.	Male/Female
(Full) – Half – Step	**3**	**3'5**	**45**	M (F)
Full – Half – Step				M F
Full – Half – Step				M F
Full – Half – Step				M F
Full – Half – Step				M F
Full – Half – Step				M F

Circle if there is a family history of: (note: includes extended family- grandparents, aunts, uncles, cousins…)

(Diabetes)	Thyroid Problems	(Obesity)	Weight loss surgery
Peptic Ulcer	Reflux	(Cancer)	(Eating disorders)
Gallbladder	Liver disease	ADHD	Seizure
Pancreatitis	Constipation	Anxiety	Depression
Arthritis	Hypertension	Mental Retardation	Learning problems
Stroke	Heart disease	Personality disorder	Other:_____
Infertility	Kidney disease	Schizophrenia	

SOCIAL HISTORY:

Caregiver marital status: **PLEASE CIRCLE**

(0-Married)
1-Divorced
2-Separated
3-Single
4-Widowed

Who lives at home with your child: **CIRCLE ALL THAT APPLY**

(0-Mother)
(1-Father)
(2-Sibling(s))
3-Grandparent(s)
4-Extended Family

Does your child go to day care: Yes (No) Sitter: Yes (No)

What is the quality of your child's relations with other kids: Poor Fair (Average) Excellent

Is your child happy: Yes No, please explain: **Yes**_____

What school and grade is your child in: **Elementary, Kindergarten**_____

How is your child's school performance: Poor (Fair) Average Excellent

Does your child have either an IEP: Yes No or 504 plan: Yes (No)

If yes, please detail:_____

Hours of television/night: **3**_____Computer/night:_**1**_____Video games/night: **0**_____

If your child plays video games, what kind: _____

How does your child spend free time? Please explain: **watching TV**_____

Child's energy level:(Low) Average High

Physical activity at home: **no**_____

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Parents involved: Yes No

Physical Education at school or play groups: (Yes) No, How often: **2x per week for ½ hour each day**

Hours of after-school organized sports a week: **0**

Mother's highest level of education: **PLEASE CIRCLE**

0-High School
(1-GED)
2-Some College
3-College Degree
4-Graduate Degree

Mother's Occupation: **Homemaker** and number of hours worked/week: **full-time**

Father's highest level of education: **PLEASE CIRCLE**

0-High School
1-GED
2-Some College
(3-College Degree)
4-Graduate Degree

Father's Occupation: **Accountant** and number of hours worked/week: **50**

Primary caregiver's work schedule: **CIRCLE ALL THAT APPLY**

(0-Weekends)
(1-Weekdays)
(2-Days)
(3-Nights)

Any significant changes in the family in the past 6 months: **no**

Is there anyone involved in the child's life that may not be supportive of weight loss: Yes (No)

If yes, what is their relationship to your child: _____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD

0-Sit Up: **6 mos**
1-Walk: **11 mos**
3-Toilet Train: **18 mos**

MEDICATIONS: Please list all medications within the last 3 months (include vitamins, health food remedies,
etc.)_____

_____

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REVIEW OF SYSTEMS:

Does your child have any of these symptoms:

			Comments
Allergy	(Yes)	No	**Pollen**
Bleeding Tendency	Yes	(No)	
Headaches	(Yes)	No	**When hungry**
Morning Headaches	Yes	(No)	
Trouble breathing	Yes	(No)	
Shortness of Breath	Yes	(No)	
Heavy Breathing	(Yes)	No	
Asthma	(Yes)	No	
Snoring	(Yes)	No	Sleep study: **no**
Snores Loudly	(Yes)	No	
Mouth open during the day	Yes	(No)	
Heartburn	Yes	(No)	
Abdominal Pain	Yes	(No)	
Constipation	Yes	(No)	
Diarrhea	Yes	(No)	
Bedwetting/urinary problems	Yes	(No)	
Joint problems	Yes	(No)	
Tired in the morning	(Yes)	No	
Sleepy in school	Yes	(No)	
Easily distracted	Yes	(No)	
Difficulty organizing	Yes	(No)	
Interrupts conversations	Yes	(No)	
Wears glasses	(Yes)	No	
Trouble following directions	Yes	(No)	
Gagging	Yes	(No)	
Vomiting	Yes	(No)	
Frequent ear infections	Yes	(No)	

Has your child ever been treated for the following conditions:

			Comments
ADHD	Yes	(No)	
ODD	Yes	(No)	
Anxiety	Yes	(No)	
Depression	Yes	(No)	
Mental Health Conditions	Yes	(No)	please describe
Legal issues	Yes	(No)	
Behavior issues	Yes	(No)	please describe:

Does your child currently see a mental health professional? (school counselor, social worker, psychologist, psychiatrist, etc) Yes (No)

Please provide their name and reasons for therapy:_____

_____

Has your child seen a mental health professional in the past? (school counselor, social worker, psychologist, psychiatrist, etc) Yes (No)

FOR THE CHILD TO ANSWER: Do you want to lose weight? (Yes) No

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EXERCISE LOG

Please keep track of your daily activities for three (3) days. If you did not have any exercise, please check the box below to acknowledge no activity during that time.

DAY	DATE	EXERCISE	MINUTES/STEPS
Monday	**11/16**	**Jump Rope**	**10 min**
Wednesday	**11/18**	**Bike Ride**	**20 min**
Friday	**11/20**	**Walk the dog**	**15 min**

☐ **I did not have any physical activity for these 3 days.**

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WEIGH SMART JR. PROGRAM FOOD INTAKE RECORD (to be recorded before returning this form).

Name of Child: **Julia Jacobs** Dates Recorded: **11/16-11/18**

Instructions: Write down everything your child eats (include sauces and drinks) **during the next 3 days**. To ensure accurate results, record the information whenever anything is eaten and/or any beverages.

Day	Time of Day	Food/Drink Description	Amount Eaten	Location of meal	How I feel
1	8:00am	Orange Juice 12oz, lucky charms cereal with Whole milk	1 bowl	In front of TV	Still Hungry
	12:00pm	Chicken nuggets, large fries, large coke	6 piece chicken nuggets, side of fries	Cafeteria at school	Full
	3:00pm	Peanut butter jelly sandwich, coke	Half	On bed	Still hungry
	6:00pm	Baked chicken, mashed potatoes, green beans, vanilla ice cream, coke	1 plate	In front of TV	Full