Healthy Weight & Wellness Program

Patient/Family Information

Child's Name: _____ Date of Birth: _____ / _____ /_____

Enrollment Date: _____ / _____ / _____

Parent Information (Maternal)

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Parent's Email (mother or father/ best contact email): _____

Race:

- ☐ African American
- ☐ Asian/Pacific Islander
- ☐ Caucasian
- ☐ Native American

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Highest Grade Level Completed: _____ Occupation: _____

Do you have insurance for yourself? _____ Yes _____ No

If so, what is the name of the insurance provider?_____

Parent Information (Paternal)

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Parent's Email (mother or father/ best contact email): _____

Race:

- ☐ African American
- ☐ Asian/Pacific Islander
- ☐ Caucasian
- ☐ Native American

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Highest Grade Level Completed: _____ Occupation: _____

Do you have insurance for yourself? _____ Yes _____ No

If so, what is the name of the insurance provider?_____

Child Information

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Race:

- ☐ African American
- ☐ Asian/Pacific Islander
- ☐ Caucasian
- ☐ Native American

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Highest Grade Level Completed: _____ Occupation: _____

Do you have insurance for yourself? _____ Yes _____ No

If so, what is the name of the insurance provider?_____

AdventHealth for Children

Patient/Family Information

Current Household Information

How many family members are in the current household? _____ Combined Annual Household Income $ _____

Are you eligible for free or reduced lunches? _____Yes _____ No

Do other family members living in your home have any of the following issues?

- ☐ Serious Illness or Chronic Illness: _____
- ☐ High Blood Pressure: _____
- ☐ High Cholesterol: _____
- ☐ Diabetes Type I or Type II: _____
- ☐ Concerns Regarding Their Weight: _____
- ☐ Restrictions From Exercise or Sports: _____
- ☐ Mental Health Diagnosis: _____

Consent for Participation & Research

** The information you have provided in completing this and all other forms will assist us in assessing your child/teen's problem areas and in establishing their individual program regimen. We would like to ask for your consent to use the above-listed information for research purposes only. All the information contained is confidential and is only used for statistical reporting in areas contributing to weight-management outcomes. This general consent also agrees to before and after photography of your child's progress. These photographs are strictly for you, your child and our practitioners to visualize the difference achieved in your family's progress; these photos will not be published or shared with other providers outside the AdventHealth Pediatric Weight and Wellness staff.

**We also have an opportunity for parents to further participate in their children's treatment and research by having our staff track your measurements, including, but not limited to, height, weight, body mass index (BMI), body fat percentage (muscle mass, fat mass, basal metabolic rate), body composition (waist circumference, hip circumference, ratio of waist/hip circumference), and mental health concerns and diagnoses.

By signing below, you authorize AdventHealth Pediatric Weight and Wellness to use your information in a confidential research database and potential publishing of confidential results (no identifying markers will be used) involving socioeconomic status, cultural contributions and parental medical information in clinical/medical research components.

Parent/Guardian Signature: _____ Date: _____ / _____ / _____

Patient Behavioral & Lifestyle Assessment (New Patient Visit)

Child's Name: _____ Date of Birth: _____ / _____ / _____

Parent Name: _____ Relationship: _____ Date: _____ / _____ / _____

Weight History:

_____

_____

Please rate how worried you are about your child's/teen's weight at this time (from 1-5, circle one).

1 – Not Concerned **2** – Somewhat Concerned **3** – Concerned **4** – Very Concerned **5** – Extremely Concerned

At what age did your child's/teen's weight become a concern? _____

What kinds of things has your child/teen tried to lose weight? (Please check or specify which by name.):

- ☐ Atkins
- ☐ South Beach
- ☐ Jenny Craig
- ☐ Weight Watchers
- ☐ Zone
- ☐ Otro: _____

Herbal Supplements, Medications: _____

Other: _____

Were any of these effective? (Please share the successes and barriers in as much detail as possible.): _____

_____

Please describe you and your child/teen's general health goals and improvements you wish to make. _____

_____

Nutrition

(Note: Questions generally relate to your child's/teen's behaviors over the past three to four months.)

Flavored/Sweetened Beverages

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

☐ 6 or more servings per day	☐ 2 servings per day
☐ 5 servings per day	☐ 1 serving per day
☐ 4 servings per day	☐ 0 servings per day/none
☐ 3 servings per day	

Vegetables (Do not include french fries in your count.)

Evaluate the average number of fist-size servings of vegetables that your child/teen eats each day. Your child's serving should be the size of their fist = 1 serving. Examples: broccoli, carrots, green beans, mushrooms, peas, squash, sweet potatoes, tomatoes and turnip greens.

☐ 5 or more servings per day of vegetables	☐ 2 servings per day of vegetables
☐ 4 servings per day of vegetables	☐ 1 serving per day of vegetables
☐ 3 servings per day of vegetables	☐ 0 servings per day of vegetables/none

Fruits

Evaluate the average number of fist-size or whole-piece servings of fruits your child/teen eats each day. Examples: apples, grapes, mangoes, oranges, papayas, peaches, pineapple, strawberries and watermelon. **Do not count fruit juice for this question.**

☐ 4 or more servings per day of fruit	☐ 1 serving per day of fruit
☐ 3 servings per day of fruit	☐ 0 serving per day of fruit/none
☐ 2 servings per day of fruit	

Milk and Dairy Products

This includes yogurt, milk (8oz), cheese (1 oz). **Circle type of milk: Whole, 2%, 1%, fat-free, soy/almond milk**

☐ 3 servings per day of milk/dairy foods	☐ 1 serving per day of milk/dairy foods
☐ 2 servings per day of milk/dairy foods	☐ 0 servings per day of milk/dairy foods/ none

Fast Food/ Eating Out/Take-Out Food

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

(Examples: McDonalds, Chick-fil-A, Carrabba's, Chili's, buffets, sit-down or take-out food.)

☐ 5 or more servings per week (fast food/take-out)	☐ 2 servings per week (fast food/take-out)
☐ 4 servings per week (fast food/take-out)	☐ 1 serving per week (fast food/take-out)
☐ 3 servings per week (fast food/take-out)	☐ Not at all (no fast food/take-out)

Please circle all the foods in each category that your family will consume/eat.

Grains/Breads/Cereals, Circle all that apply.

White Bread	Cereal Oatmeal	Tortillas Chips
Wheat Bread	Regular Pasta	
White Rice	Wheat Pasta Amaranth	
Brown Rice	Bulgar	

Meats, Circle all that apply.

Chicken	Hot Dogs	Bacon
Pork	Turkey	Veal
Beef	Ham	
Sausage	Roast Beef	

How many days per week does your child/teen consume/eat fried foods?

(Examples: fried fish, fried chicken, fried cheese sticks, onion rings, French fries)

Most Days	Some Days	Rarely

Water

Estimate how many 8-ounce servings of water your child/teen drinks on average or a typical day.

☐ 8 or more servings per day of water	☐ 2-3 servings per day of water
☐ 6-7 servings per day of water	☐ 1 serving per day of water
☐ 4-5 servings per day of water	☐ 0 servings per day of water

Problem-Eating Areas (Please check all that apply specifically to your child/teen.)

☐ Sometimes hides when eating/sneaks food	☐ Usually skips meals
☐ Is rewarded with food at home (reward system)	☐ Eats when angry or stressed
☐ Is never sure when full	☐ Eats when feeling sad or depressed
☐ Loves sweets and can't stay away from them	☐ Eats when feeling happy
☐ Eats too large of portions or more than 2 servings	☐ Eats when feeling bored
☐ Eats unhealthy foods (fried food, fast food, candy, sweets)	☐ Eats meals at the wrong time of day (ex: late at night/after 9 or 10 pm)

Emotional/Behavioral Eating (Binge-Type Eating)

Does your child/teem 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

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/teen experience a loss of control? ☐ Yes ☐ No

Does your child/teen express feelings of guilt and share after engaging in such eating patterns? ☐ Yes ☐ No

Right after binging, does your child/teen ever fast (refuse to eat), exercise excessively, use laxatives, or vomit?

☐No ☐Yes (Check which behavior(s). ☐Fasting ☐Excessive Exercising ☐Use of Laxatives ☐Vomiting

Physical Activity/ Exercise

How often does your child/teen exercise? Please check off how many minutes per day and how many times per week your child/teen does any exercise/physical activity (please include time they spends in a 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?
☐ 5-10 minutes per day	☐ 7 days per week	☐ 0 days 1 day 2 days
☐ 10-20 minutes per day	☐ 5-6 days per week	☐ 3 days 4 days 5 days
☐ 20-30 minutes per day	☐ 3-4 days per week	
☐ 30-40 minutes per day	☐ 1-2 days per week	**How many days per week does your child have recess?**
☐ 40-50 minutes per day	☐ None	☐ 0 days 1 day 2 days
☐ 50-60 minutes per day		☐ 3 days 4 days 5 days
☐ 60+ minutes per day		

What types of exercise does your child/teen engage in?

☐ Planned Walk	☐ Playground Equipment
☐ Walking Briskly (Heartbeat is Faster)	☐ Soccer
☐ Biking (Bike Ride or Spinning Class)	☐ Basketball
☐ Group Exercise (Aerobics or Dancing)	☐ Baseball/Softball
☐ Swimming	☐ Football
☐ Martial Arts/Karate	☐ Volleyball

☐ Other: _____

On average, how many days per week do you exercise as a family (parent and child/teen)?

☐ None	☐ 3-4 days	☐ Daily
☐ 1-2 days	☐ 5-6 days	

Sleep/Screen Time:

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

☐ 11 pm or later	☐ 9 pm	☐ 7 pm
☐ 10 pm	☐ 8 pm	

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

☐ 9 am or later	☐ 7 am	☐ 5 am
☐ 8 am	☐ 6 am	

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

If YES, how many times does your child/teen 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/teen feel rested when waking up in the morning? ☐ No ☐ Yes ☐ Sometimes

How often does your child nap?		
☐ 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/teen fall asleep using electronic devices (TV, computer/tablet, cell phone, etc.)? ☐ Yes ☐ No

Screen Time (TV/Internet/Video Games)

Check the amount of screen time/electronic media exposure your child/teen usually gets per day (this includes television, videos, YouTube, Netflix, Hulu, cellphone, video games and computer/tablet activities).

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

Body Image

Does your child feel ashamed of their body? ☐ Yes ☐ No

Is your child being teased or bullied by others about their weight or body? ☐ Yes ☐ No ☐ I don't know

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				

Thank you for your time and effort in completing our questionnaire.

Psychological-Pediatric Symptom Checklist (PSC)-Parent Form

AdventHealth for Children

Child's Name: _____ Child's Age:_____ Date of Birth: _____ / _____/ _____

Completed by: _____ Relationship: _____

Please mark under the heading that best describes your child.	**Never**	**Sometimes**	**Always**
Complains of aches and pains			
Spends more time alone			
Tires easily, has little energy			
Fidgety, unable to sit still			
Has trouble with teachers			
Less interested in school			
Acts as if driven by a motor			
Daydreams too much			
Distracted easily			
Is afraid of new situations			
Feels sad, unhappy			
Is irritable, angry			
Feels hopeless			
Has trouble concentrating			
Less interested in friends			
Fights with other children			
Absent from school			
School grades dropping			
Is down on themselves			
Visits the doctor with doctor finding nothing wrong			
Has trouble sleeping			
Worries a lot			
Wants to be with you more than before			
Feels that they are bad			
Takes unnecessary risks			
Gets hurt frequently			
Seems to be having less fun			
Acts younger than children their age			
Does not listen to rules			
Does not show feelings			
Does not understand other people's feelings			
Teases others			
Blames others for their troubles			
Takes things that do not belong to them			
Refuses to share			

Does your child have any emotional or behavioral problems for which they need help? ☐ Yes ☐ No

Is your child currently seeing a mental health counselor/provider? ☐ Yes ☐ No

Has your child been hospitalized (or Baker Acted) for mental/emotional health reasons in the past 12 months? ☐ Yes ☐ No

[For Provider Use: TOTAL SCORE _____ (☐ Clinically Significant ☐ Not Clinically Significant)]

AdventHealth for Children

Psychological Initial Clinical Interview Form

(Rev:3/2020-Parent Form)

Child's Name: _____ Date Form Completed: _____ / _____ / _____

Child's Information:

Age: _____ Grade: _____ School Name: _____ Gender: ☐ Male ☐ Female

Who lives/resides in the home? _____

This form was filled out by (please specify your relationship to the child): _____

Presenting Problems: *Please check any current issues/concerns about your child.*

☐ Sadness/Unhappiness	☐ Sleeping Problems	☐ Disobedience
☐ Crying Spells	☐ Worry/Anxiety	☐ Impulsiveness/Interrupts Other
☐ Irritable Mood	☐ Social Isolation/Withdraws From Others	☐ Suicidal Thoughts/Attempts
☐ Lack of Interest in Usual Things	☐ Body Image Issues	☐ Self-Mutilation (Hurting, Cutting Self)
☐ Low Self-Confidence and Self-Esteem	☐ Difficulty Paying Attention	☐ Substance Abuse(Alcohol/Drugs)
☐ Anger Outbursts	☐ Restlessness/Constant Motion	☐ Other (Please describe below.)

Other Current Mental/Behavioral Health Concerns: _____

_____

_____

History of Presenting Symptoms

Was your child ever diagnosed with a mental health disorder? ☐ Yes ☐ No

If yes, please list all mental health diagnoses and year of each diagnosis. _____

_____

Past/Current Mental Health Services:

☐ Outpatient (Individual, Family, Or Group Therapy): _____

☐ Mental Health Hospitalizations/Baker Act/ Inpatient/ Residential Facility: _____

Current Psychotropic Medications *(Medications For Mental Health Symptoms/Disorders) List names please.*

Medications: _____ ☐ None

Who prescribes the current medications? _____

Are the medications effective? ☐ Yes ☐ No ☐ Somewhat

Family History of Psychological Problems (Parents, Siblings, Grandparents, etc.): _____

_____

Motivation For Weight Management & Lifestyle Changes

Child's/Teen's Current Motivation for Health/Weight Behavior Changes (Check one.):

☐ 1 – Not Motivated ☐ 2 – Slightly Motivated ☐ 3 – Motivated ☐ 4 – Very Motivated ☐ 5 – Extremely Motivated

Strengths for Lifestyle Changes: _____

Barriers for Lifestyle Changes: _____

Medical Problems

Child Abuse History

Is your child currently experiencing child abuse? ☐ Yes ☐ No

If yes, please specify type. ☐ Physical ☐ Sexual ☐ Emotional By Whom: _____

Was your child ever exposed to domestic violence? ☐ Yes ☐ No

If yes, please explain. _____

Legal History

Has your child ever been incarcerated (arrested/in jail)? ☐ Yes ☐ No

If yes, please explain. _____

AdventHealth for Children

Program Commitment Form

Our Commitment to You

- Provide family-oriented individualized professional health and wellness care for your child including:
  - Frequent opportunities to learn, participate in and enjoy physical activity
  - Ways to improve health through nutrition and healthy food choices
  - Exploration of behavioral strategies to meet health and wellness goals
  - Medical management of weight and weight-related issues as a supplement to the care provided by your child's primary care doctor
- Provide meaningful health coaching and support as needed either in person, by phone or through email
- Keep any scheduled appointments made, maintain punctuality and reschedule only under major unforeseen circumstances
- Communicate frequently with your child's primary doctor

Your Commitment to This Program and Your Health

- Attend all scheduled appointments. If you are unable to keep an appointment, please provide us with 24-hours notice of cancellation.
- Complete all core educational workshops within 4 months of program enrollment.
- Attend additional workshops and special events.
- Complete all required lab work within one week of all medical evaluation appointment dates (lab work is done every six months unless it is deemed necessary to be done more frequently).
- Family will put forth your BEST EFFORT at making changes to become a healthier YOU.

***** It is vital that you understand the commitment that this program requires. It is only through attendance at provider visits and educational workshops, in addition to consistent practice of goals made, that your family will succeed. Your success, measured in the form of your child's long-term health and wellbeing, is truly our ultimate goal. *****

AdventHealth for Children's Healthy Weight and Wellness Program and Pediatric Weight and Wellness look forward to serving you and your family during this exciting new journey towards healthier change. We welcome all feedback from parents and patients to continue to make this program a success for our children and community.

Commit to Be Fit

- I COMMIT to actively make healthier food choices.
- I COMMIT to daily exercise and stretching, and in any activity I enjoy — keeping my body and mind fit while revenging injury.
- I COMMIT to sleep and rest — making sure I get enough sleep each night to replenish my energy. I will also do my best to get some "down-time" during the course of each day to relax.
- I COMMIT to following the recommendations and healthy assignments made by my wellness team (physician, psychologist, dietitian, exercise physiologist and/or health coach, if applicable). I will actively participate in workshops and individualized sessions. We will work together as a family to make healthy lifestyle changes.
- I COMMIT to JOY by making and taking the time each day to be with people, go to places, and do things that make me laugh and feel happy.

Please acknowledge that you have received this form and understand its entirety by signing below.

Signature of Child: _____ Date: _____ / _____ / _____

Signature of Parent: _____ Date: _____ / _____ / _____

AdventHealth for Children

RELEASE FORM FOR FITNESS AND EXERCISE

HEALTHY WEIGHT & WELLNESS PROGRAM

The AdventHealth Healthy Weight & Wellness Program offers individual physical fitness programs ("Activities"). The Activities will take place at AdventHealth, Pediatric Weight and Wellness, or other locations designated by AdventHealth. Individuals enrolled in the program are eligible to participate in activities sponsored by the program upon the completion of their registration or release ("form").

RELEASE

In consideration of being permitted to participate in the Healthy Weight & Wellness program, I hereby agree to release AdventHealth, Pediatric Weight and Wellness, their respective agents, officers, directors, and employees, of any form any and all liability, claims, demands or causes of action whatsoever arising out of or related to any loss to any loss, damage, or injury, including death, that may be sustained by me, or any property of mine, while participating in, waiting to participate in, or en route to participate in Program Activities.

I further agree to indemnify and hold harmless AdventHealth, Pediatric Weight and Wellness, and their respective officers, employees, directors, and agents against all claims, losses, damages and costs, including but not limited to court costs and reasonable attorney's fee on account of any injury (including my death) to myself or my property arising out of my participation in Program Activities.

Being aware that participation in sports or physical activities can be physically demanding and can result in accidents or injuries (i.e. those risks inherent in any sport/exercise activity regardless of the medical condition of the participant) including, in rare instances, death, the program has advised me that I should consult with my own physician and obtain their opinion as to the advisability of my participating a program activities.

I realize that I will be instructed by program personnel, during the activities I hereby recognize I must adhere to these instructions, or I will forfeit my privileges to participate in the program.

I hereby represent to the Healthy Weight & Wellness Program that I am in good health and suffer from no physical impairment (other than the problems stated on my participant information sheet) that would limit my ability to participate in program activities. I acknowledge that neither the program nor its coaches, instructors, employees, or agents have rendered any medical advice to me or given any opinion or diagnosis of my current medical condition nor are they authorized to do so. If my physical condition should ever change or if I should experience difficulty when participating in any program activity, I agree to discontinue my participation until I consult with my personal physician.

Name of Child (please print): _____

Name of Parent/Legal Guardian (please print): _____

Signature of Parent/Legal Guardian: _____

AdventHealth for Children

To Maximize the time the team spends with you and your child and to minimize your wait time, we are introducing a No-Show and Late Arrival Policy that will take effect immediately.

No-Show Policy

We will implement a “no-show” policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- Orientation Session- Patient/parent informed of and signs the No-Show Policy.
- First Occurrence- Patient/parent will receive a warning reminder letter of the No-Show Policy.
- Second Occurrence- Patient/parent will receive a call informing them that the No-Show Policy reminder letter was sent and inform them of the result should a third no-show occur.
- Third Occurrence- Will result in dismissal from the program and a letter to the PCP will be sent informing them of non-compliance.

Late Arrival Policy

- Orientation Session- Patient/parent informed of and signs the Late Arrival Policy.
- Parents arriving more than 10 minutes late for a scheduled appointment will be rescheduled for another day.
- In the event you will need to reschedule, please keep in mind that due to the high demand of this program, this could result in a delay in your program participation of up to 2-3 months or more for the next available appointment.
- We appreciate courtesy calls informing us that you will be more than 10 minutes late, as this will allow you to reschedule and will not be counted as a no-show appointment (see above no-show policy).

Patient Name: _____

Parent/ Guardian Signature: _____

Date: _____ / _____ / _____