



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

| |
|-----------------------------------|
| Label |
| Last Name, _____ First Name _____ |
| Med Rec # _____ or _____ |
| Date of Birth _____ |

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 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 | <input checked="" type="checkbox"/> No |
| Gagging? | _____ Yes | <input checked="" type="checkbox"/> No |

If vomiting is a problem, when does vomiting occur?

| | | |
|-----------------------|-----------|--|
| During feeding? | _____ Yes | <input checked="" type="checkbox"/> 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. <input checked="" type="radio"/> Watery | c. Pasty |
| b. <input type="radio"/> Formed | d. <input type="radio"/> 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**

- | | |
|---|---------------|
| <input checked="" type="radio"/> 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
- 1-Fresh Fruit (whole fruit, not juice)
- 2-Chips
- 3-Sandwiches
- 4-Granola
- 5-Cereal
- 6-Yogurt
- 7-Nuts
- 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)

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Eats too fast | <input type="checkbox"/> Eats too little | <input checked="" type="checkbox"/> Messy eater |
| <input type="checkbox"/> Eats too slow | <input checked="" type="checkbox"/> Eats too much | <input type="checkbox"/> Plays with food |
| <input type="checkbox"/> Does not chew | <input type="checkbox"/> Pushes food away | <input type="checkbox"/> Leaves table |
| <input type="checkbox"/> Eats non-food items | <input type="checkbox"/> Sneaks food | <input type="checkbox"/> Picky eater |
| <input type="checkbox"/> Spits food out | <input type="checkbox"/> Refuses to open mouth | <input type="checkbox"/> Drools |
| <input checked="" type="checkbox"/> Throws/drops food | <input checked="" type="checkbox"/> Takes food from others | <input type="checkbox"/> Ruminates |
| <input type="checkbox"/> Cries or tantrums | <input type="checkbox"/> Refuses to swallow food | <input type="checkbox"/> Vomits/gags |
| <input type="checkbox"/> Turns away from spoon | | |
- Other _____

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Coax | <input type="checkbox"/> Distract with toys | <input type="checkbox"/> Limit foods |
| <input checked="" type="checkbox"/> Threaten | <input type="checkbox"/> Change meal schedule | <input type="checkbox"/> Spank |
| <input checked="" type="checkbox"/> Offer reward | <input type="checkbox"/> Mini-meals | <input type="checkbox"/> Force feed |
| <input type="checkbox"/> Ignore | <input type="checkbox"/> Praise | <input checked="" type="checkbox"/> Use television |
| <input checked="" type="checkbox"/> Send to room/time out | <input type="checkbox"/> 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

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 |
|---|----------|------------|-----------|--------------------------------------|
| <input checked="" type="radio"/> Full - Half - Step | <u>3</u> | <u>3'5</u> | <u>45</u> | M <input checked="" type="radio"/> 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...)

| | | | |
|---|------------------|--|---|
| <input checked="" type="radio"/> Diabetes | Thyroid Problems | <input checked="" type="radio"/> Obesity | Weight loss surgery |
| Peptic Ulcer | Reflux | <input checked="" type="radio"/> Cancer | <input checked="" type="radio"/> 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** _____

94:02:09:09

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Parents involved: Yes No

Physical Education at school or play groups: Yes No, How often: 2x per week for 1/2 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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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.

