Weigh to Wellness Denver
Nutrition and Fitness for Weight Management for Adults, Children and Families
Dr. Rebecca Andrick drandrick@wtwdenver.com 303-321-2383

Child Health History Form

Date: _____

Please use blue or black ink, thank you.

Patient Name:_____
Birth date: _____ Age: _____
Primary Care Provider: _____
ALLERGIES: _____

History of Present Condition:

Please describe your child's weight or nutrition problem. When did it begin?

_____
_____
_____

Child's weight at birth? _____
Full term pregnancy? Yes or no. How many weeks premature? _____
Child breast fed? If yes, number of months?_____

Current Dietary Habits

Typical Meal	Breakfast	Lunch	Dinner	Snacks/Desserts
Foods types and how much?		School lunch or lunch from home?		Mid morning? Mid afternoon? Evening snack? Dessert?
Time?				
Place?				

How many times per week is your family going out to eat?_____
How often does your child eat Fast Food per week? (ie: McDonald's, Taco Bell)?_____
What might they eat? _____How much soda____, juice____, milk____, water____ Does your child drink daily? Who plans meals? _____ Shops?_____ Cooks?_____
Is your child a picky eater? _____. Vegetable servings daily? _____ Fruit servings daily?_____ Does the family eat whole grain bread, cereals, and pasta? _____

Current Physical Activities

Activity?			
Time spent?			
Frequency?			

What types of physical activities does your child really enjoy? _____
When does exercise fit into the child and family's schedule work best? _____
What resources do you have available to help your child be more active? Recreation Center, pool, league sports, etc..____
_____

Social History

Parents marital status? _____. Mom and Dad Name/Age/Overweight?_____
How many children or other persons are living with you? _____
What is the child's living situation?_____
What school does your child attend? _____Time in ? _____
Time out?_____ What grade is your child in?_____
Activity level at school? _____. PE time? _____. Recess time? _____

How many hours of screen time does your child have daily? (includes: TV, computer, video games)_____
Teens: Do you know of any ETOH, recreational drugs, substance abuse, cigarette smoking your teen may be using?_____

What was your family culture like with regards to food?
Does your family sit and eat together? _____ How many nights per week? _____
Do you require your child to "clean their plate"? _____
Do you give food as a reward for good behavior or achievements? _____
Does your child use food now to relieve stress or for "comfort"? _____

Past Medical History (Please circle all that apply)

*Diabetes (or high blood sugar) *High Blood Pressure *Abnormal Cholesterol *Liver Disease *Eating Disorder *Heart disease *Sleep Apnea *PCOS (polycystic ovarian disease) *Depression *ADHD *Anxiety *Behavioral Problems *Developmental Problems (How old when they started?) _____
Other Medical problems:_____
_____

Girls: Early or delayed puberty? _____Is your daughter having periods now and at what age did they start? _____
If yes: Are periods regular and monthly or irregular? _____

Past Surgical History

Surgery Type	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications

Please include all prescription medications, vitamins and supplements and over the counter drugs.

Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Family History

Relative	Age	Living	Medical Problems? Are they Overweight?
Mother			
Father			
Sibling (sis or brother?			
Sibling			
Sibling			
Mother's Mother (GM) Mother's Father (GF)			
Father's Mother (GM) Father's Father (GF)			
Family with early onset of heart disease/ cancer			

Review of Systems (circle all that apply)

of Sleep hours/night_____ Bedtime?_____ Wake time?_____ Snoring Apnea (waking due to stopping breathing) Fever Chills Night sweats Fatigue Weakness
Neck or jaw swelling Chronic nasal congestion Difficulty swallowing
Chest pain (if yes, with or without activity?) Shortness of breath with activity Palpitations Jaw, shoulder or arm pain with activity?
Wheezing of cough with physical activity? Chronic cough Shortness of breath at rest
Heartburn Constipation Diarrhea Blood in Stools Excess Gas Nausea Vomiting Abdominal Pain
Excessive thirst Excessive Water intake Hair loss Intolerance of heat or cold
Frequent urination Large volumes of urine Blood in urine Waking to Urinate
Numbness or Tingling in Extremities Burning or Pain in Extremities Headaches
Joint Pain (Which? _____) Muscle Pain (Where? _____) Swelling in extremities (Where?_____)
Feeling sad Feeling anxious Excessive Stress Binging on Food Sleep Disturbed Insomnia Guilt or Shame After Eating Hiding Food
Acne Skin Rash Dark Skin lesions in folds of skin
Girls only: Excess facial hair Nipple hair Lower Abdominal hair Nipple Discharge

Preventative Medical Care Status

Date of most recent blood work? Where done? _____

Test/Exam	Date	Nl.	Abn.	Results
Physical				
Lipid Profile				Tot. LDL HDL Trig.
TSH/Thyroid test				
Pap Smear				
Hgb A1C				

Weigh to Wellness Denver

Nutrition and Fitness for Weight Management for Adults, Children and Families

Name: _____

Date: _____

Welcome! Please help us get to know you.

1. **I am here for assistance with:**
   - ○ Weight Reduction
   - ○ Gastrointestinal Issues
   - ○ Bariatric Surgery Preparation or Follow Up
   - ○ Nutritional Deficiencies
   - ○ Food Allergies
   - ○ Food Sensitivities
   - ○ Other _____

2. **If you're here for weight reduction, tell us what you are looking for:**
   - ○ I'd like to lose 1 lb. per week (moderate calorie deficit)
   - ○ I'd like to lose 2 lbs. per week (more significant calorie deficit)
   - ○ I'd like to lose 3 lbs. or more per week (very low calorie diet)
   - ○ Other _____

3. **Tell us how we can help you best achieve your goals: (circle all that apply)**

My Knowledge of Nutrition is:	Minimal to Fair	Fair to Good	Great
I need a meal plan that is:	Flexible	More Specific	Very Structured
Weight loss medication options:	Interested	Not Interested	I would like to know more
Discuss Bariatric surgery:	Interested	Not Interested	I would like to know more
I'd like to meet with an exercise physiologist:	Interested	Not Interested	I would like to know more
Treatment for emotional eating:	Interested	Not Interested	I would like to know more

4. **I work best if I have: (check all that apply)**
   - ○ Something structured to follow
   - ○ Guidance with flexibility to follow an individual program
   - ○ Frequent Visits (weekly, bimonthly, monthly) to suit my needs
   - ○ Specific goal setting intervals (long and short term)
   - ○ Immediate results, so I don't give up

5. **I follow a diet that is (check all that apply)**
   - ○ Gluten Free
   - ○ Dairy Free
   - ○ Vegetarian
   - ○ Clean, little processed food
   - ○ Food Allergy Restricted
   - ○ Low Carb/High Protein
   - ○ Other _____

6. **Anything else you would like us to know about you?** _____
   _____
   _____

7. Rate your Plate (put a check mark in the column (A,B, or C) that applies to you)

Topic	A	B	C
Red Meat: Beef, hamburger, pork, lamb, veal	**Usually Eat:** Three times a week or more	**Usually Eat:** Twice a week	**Usually Eat:** Once week or less
Chicken, Turkey, etc.	**Usually Eat:** Chicken, turkey and other poultry with skin	**Sometimes Eat:** Chicken, turkey and other poultry with skin	**Usually Eat:** Chicken, turkey and other poultry without skin
Fish	**Usually Eat**: less than once a week	**Usually Eat:** once a week	**Usually Eat**: twice a week or more
Cold cuts, hot dogs, breakfast meats	**Usually Eat:** Salami, bologna, other cold cuts, hot dogs, bacon, sausage	**Sometimes Eat:** Salami, bologna, other cold cuts, hot dogs bacon, sausage	**Usually Eat:** lean deli meat or, I **rarely eat** processed meat
Portion Sizes	Large	Medium	Small
Eating out: restaurants or fast food	**Usually Eat:** Three or more times per week	**Usually Eat:** 1-2 times per week	**Usually Eat:** Once a week or less
Milk	**Usually Drink:** Whole milk or cream	**Usually Drink:** 2% reduced fat milk	**Usually Drink:** 1% low-fat or skim milk
Dairy Servings per day	**0-1**	**1-2**	**2-3**
Cooking method	**Usually Add:** Oil, butter or margarine to the pan	**Sometimes Add:** oil, butter or margarine to the pan	**Usually Use:** Cooking spray, minimal olive or canola oil
Fried foods	**Usually Eat:** Fried foods	**Sometimes Eat:** Fried foods	**Rarely Eat:** Fried Foods
Spreads, condiments, dressings	**Large Amount or Frequently:** Creamy salad dressings, butter, high fat sauces and and/or gravy	**Moderate Amount or Sometimes:** Creamy salad dressings, butter, high fat sauces and/or gravy	**Small Amount:** Light dressings, margarine and lower fat sauces
Snacks	**Usually Eat:** Chips and/or crackers	**Sometimes Eat:** Chips and/or crackers	**Rarely Eat:** Chips and/or crackers
Desserts & sweets	**Usually Eat:** Donuts, cookies, cake, pie, pastry, chocolate or ice cream	**Sometimes Eat:** Donuts, cookies, cake, pie, pastry, chocolate or ice cream	**Usually Eat:** Fruit, low-fat or sugar free desserts
Grains	**Usually Eat:** White breads, white rice and/or low fiber cereals	**Sometimes Eat:** White breads, white rice and/or low fiber cereals	**Usually Eat:** Whole grain breads, brown rice and whole grain cereals
Fruits & Vegetables	**Usually Eat:** 1 serving or less per day	**Usually Eat:** 2-4 servings per day	**Usually Eat:** 5 or more servings per day
Sugar Sweetened Beverages	**Usually Drink**: 12 oz. or more of soda, juice, or other sweetened beverage a day	**Occasionally Drink:** soda, juice, or other sweetened beverage	**Usually Drink:** unsweetened or diet drinks, or water

Find your Rate Your Plate Score:

Total checks in Column A _____ X1 = _____
Total checks in Column B _____ X2 = _____
Total checks in Column C _____ X3 = _____

Total Score: _____

What does your score mean?

If your score is:

15-20 There are many ways you can make your eating habits healthier.
20-35 There are some ways you can make your eating habits healthier.
35-48 You are making many healthy choices.

What areas of your diet could be improved?

1. _____
2. _____
3. _____

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Authorization to Use or Disclose My Health Information

Patient name:_____ **Date of Birth:**_____

I. Authorization for my PCP and or referring physician(s)_____

You may use or disclose the following health care information (check all that apply):

Recent Laboratory Reports (last 1 year)

Recent Testing Reports: _____

Any health information maintained by the above named physician/practice regarding: _____

_____

You may disclose this health information to:

Weigh To Wellness Denver
Rebecca Andrick, D.O.
925 S. Niagara St. Suite #370
Denver, CO 80224

Phone: (303) 321-2383

FAX: (303) 223-3288

Reason(s) for this authorization (check all that apply):
____At my request
____Other (continuity of care)_____
This authorization ends: (on date)_____
II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or Legally Authorized Individual Signature **Date** **Time**

Rebecca M. Andrick, D.O.

925 S. Niagara St. Suite #370. Denver, CO. 80224
Phone: (303) 321-2383 Fax: (303) 223-3288

REVIEW THIS FORM THOROUGHLY; COMPLETE ALL INFORMATION IN BLACK OR BLUE INK; SIGN THE FORM -- THANK YOU

Name of Patient _____
Street Address: _____
City State Zip _____
Date of Birth: _____
Social Security #: _____
Race: Cirlce one American Indian/Alaska Native
Asian
Black/African American
Not Hawaiian/Pacific Islander
Other Race
White
Ethnicity: Cirlce one Hispanic or Non Hispanic
Primary Language: _____
Employer: _____

Account #: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Marital Status: _____
Sex: M F
Pharmacy Name: _____
Pharmacy Phone: _____

RESPONSIBLE/INSURED PERSON INFORMATION

Name: _____
Street Address: _____
City, State and Zip _____
Employer: _____

Date of Birth: _____
Social Security #:_____

	PRIMARY HEALTH INSURANCE	SECONDARY HEALTH INSURANCE
Insurance Name:	_____	_____
Group Name/Number:	_____	_____
Policy Number:	_____	_____
Policyholder Name:	_____	_____
Relationship:	_____ 1=self 2=Spouse 3=Dependent	_____ 1=self 2=Spouse 3=Dependent
Copayment:	_____	_____
Referred by:	_____	_____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

I authorize payment directly to Weigh To Wellness Denver and authorize the release of medical information necessary to process insurance claims. I voluntarily consent to treatment for myself and/or dependents.

Except under certain contractual arrangements; Medicare or Medicaid; and some participating health insurance plans, I will be responsible for the full amount of the charges at the time of service.

Signature of Patient Responsible Person _____ **Date:** _____