We look forward to being a partner in your child or teen’s care. Please fill out this form to help us get to know you and your child/teen better. The information you give us is private and confidential. You may complete this form before you come or at the time of the visit.

What is the most important concern you want to talk about at your first clinic visit?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

FAMILY HISTORY
Do any of your child/teen’s immediate family members (mother, father, brother, sister, grandparents, aunts, uncles) have/had any of the following? Check all that apply.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If yes, who:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 Diabetes</td>
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<tr>
<td>Type 2 Diabetes</td>
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<tr>
<td>Thyroid Disorder</td>
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<tr>
<td>Heart attack or Stroke before 55 years old</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Liver Disease</td>
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<td></td>
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<tr>
<td>Obstructive Sleep Apnea</td>
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</tbody>
</table>

HOUSEHOLD INFORMATION
Are biological parents

☑ Married? ☑ Divorced? ☑ Separated? ☑ Single Parent?

Who lives with the child/teen?

Number of siblings:

SCHOOL INFORMATION
Current Grade:

School Performance: ☑ Above Average ☑ Average ☑ Learning Resources ☑ Special Education

PREGNANCY/ BIRTH HISTORY
Patient Birth Weight: Birth Length:

Length of pregnancy (# of weeks)

Did Mom have any illnesses during pregnancy? ☑ Yes ☑ No

Comments:

Did Mom have diabetes during pregnancy?
If yes, did it go away after pregnancy? ☑ Yes ☑ No ☑ Yes ☑ No
## CHILD/TEEN HOSPITALIZATIONS AND SURGERIES

**Has child/teen been hospitalized or had any surgeries?** ☐ Yes ☐ No

If yes, please list reasons for hospitalization and/or surgery and the date(s).

<table>
<thead>
<tr>
<th>Hospitalization/Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

## Has your child had any of the following symptoms that interfered with daily activities? Check all that apply.

**Constitutional**
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever
- ☐ Illness
- ☐ Very Tired
- ☐ Sleep Disturbances

**Endocrine**
- ☐ Very Thirsty
- ☐ Urinating Large Amounts
- ☐ Very Hungry
- ☐ Very Tired
- ☐ Feeling Hot
- ☐ Feeling Cold
- ☐ Unusual Body Odor
- ☐ Period Before Age 9

**Dermatological**
- ☐ Rash
- ☐ Loss of Hair
- ☐ Change in Skin Color
- ☐ Stretch Marks

**Ear/Nose/Throat**
- ☐ Sore Throat
- ☐ Nasal Discharge
- ☐ Hearing Loss

**Vision**
- ☐ Eye Problems
- ☐ Vision Problems

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Snoring

**Cardiovascular**
- ☐ Heart flutter
- ☐ Chest Pain

**Gastrointestinal**
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Abdominal Pain

**Neurological**
- ☐ Frequent Headaches
- ☐ Seizures

**Psychiatric**
- ☐ Anxiety
- ☐ Depression
- ☐ Change in behavior
- ☐ Hyperactive behavior
- ☐ Easily Distracted

**Genitourinary**
- ☐ Urinating often
- ☐ Nighttime bedwetting
- ☐ Painful urination

**Musculoskeletal**
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Back Pain

**Hematological**
- ☐ Unexplained Bruising

**Immunological**
- ☐ Allergic Reaction

**None**
- ☐ None of the Above Apply
CIRCLE THE NUMBER THAT BEST DESCRIBES THE PATIENT’S LIFESTYLE CHOICES

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5+</th>
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</thead>
<tbody>
<tr>
<td>Servings per day of fruit and veggies</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hours per day of screen time: TV, video games, computer or phone time</td>
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<tr>
<td>Hours per day of play/exercise to the point of breathing hard</td>
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<tr>
<td>Days per week being active together as a family</td>
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<tr>
<td>Glasses (8oz.) per day of sugary drinks (juice, soda, sports drinks, energy drinks, flavored milk, lemonade, kool aid, sweet tea/coffee)</td>
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<tr>
<td>Meals per week together as a family</td>
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<tr>
<td>Days per week eating breakfast</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hours per night sleeping</td>
<td>&lt;6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10+</td>
</tr>
</tbody>
</table>

MENSTRUAL HISTORY (Girls only)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Has your child ever had a menstrual period?</td>
<td></td>
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<tr>
<td>If yes, what age did they start?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do periods occur regularly?</td>
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<td></td>
</tr>
<tr>
<td>Does your child have pain, severe cramps, vomiting with her menstrual periods?</td>
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<td></td>
</tr>
<tr>
<td>Ever or now using birth control pills?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WEIGHT MANAGEMENT HISTORY

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child/teen ever tried to lose weight by dieting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what type of diets?</td>
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<tr>
<td>If yes, how successful was the dieting?</td>
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</tbody>
</table>

Signature of Patient/Legally Authorized Representative ____________________________ Date ________________

Printed Name of Patient/Legally Authorized Representative ____________________________ Relationship to Patient ________________

Practitioner Signature ____________________________ Date ___________ Time ____________

Practitioner Printed Name ____________________________