



Children's Hospital of The King's Daughters, Inc.  
601 Children's Lane, Norfolk, VA 23507-1910

Healthy You Program  
**INTAKE FORM** (Page 1 of 4)

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**Child's Name:** \_\_\_\_\_ **Gender:** Male / Female  
**Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ (mm/dd/yy)  
**Person completing this form:** \_\_\_\_\_ **Relationship to the Child:** \_\_\_\_\_  
**Parent/Guardian's Date of Birth:** \_\_\_\_\_ (mm/dd/yy)

What is the preferred language for caregiver to speak? \_\_\_\_\_ to read? \_\_\_\_\_  
Is an interpreter needed when speaking with the Team? \_\_\_\_\_  
*We prefer that children not be considered as interpreters for adults in the home.*

Do you have internet at home?  Yes  No: if No, do you have daily access to your e-mail?  Yes  No  
E-mail address(es): \_\_\_\_\_ Whose e-mail is this: \_\_\_\_\_  
E-mail address(es): \_\_\_\_\_ Whose e-mail is this: \_\_\_\_\_  
*PLEASE NOTE: We do not share e-mail addresses with anyone outside of the Healthy You Program.*

**Parent/Caregiver: Please take a few minutes to fill out the following form. This will help us to know you and your child better. If your child is able, fill out the form together.**

**Family Information**

Name	Relationship to Child	Age	How would you describe his/her weight (Circle one)	Please list any health problems
			Underweight Healthy Weight Overweight	
			Underweight Healthy Weight Overweight	
			Underweight Healthy Weight Overweight	
			Underweight Healthy Weight Overweight	
			Underweight Healthy Weight Overweight	

**What family and/or friends are actively involved in your child's life?**

Name	Relationship to Child	Age	Please include anything you feel we should know about him/her

**Child's History**

Who is your child's primary care doctor? \_\_\_\_\_ Who referred your child to the Healthy You Program? \_\_\_\_\_  
Does your child currently see any other doctors? If yes, for what reason? \_\_\_\_\_

When did you first become concerned about your child's weight? \_\_\_\_\_

Has your child ever been in a weight loss or weight management program?  Yes  No If yes, please tell us about it: \_\_\_\_\_

Has your child ever been on a diet?  Yes  No Has your child ever had an exercise program (besides sports or play)?  Yes  No

If yes to either one, please tell us about it: \_\_\_\_\_  
 What have you tried recently to help with your child's weight? \_\_\_\_\_

**Family History**

Has anyone in your family ever been in a weight loss or weight management program?  Yes  No If yes, please tell us about it: \_\_\_\_\_

Has anyone in your family ever been on a diet?  Yes  No Has anyone in your family ever been in an exercise program?  Yes  No

If yes to either one, please tell us about it: \_\_\_\_\_

Please list any current or past medical problems your child has:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Your child's weight at birth: \_\_\_\_\_

Any problems after birth: \_\_\_\_\_

Please list any **surgeries** your child has had:

<u>Type</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____

Please list any **hospitalizations** your child has had:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any medications (prescribed, over-the-counter, vitamins, supplements, and herbal) your child is taking:

<u>Medication</u>	<u>Dose</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any **allergies** your child has:

<u>Medication Allergies</u>	<u>Reactions</u>
_____	_____
_____	_____
_____	_____

<u>Food Allergies</u>	<u>Reactions</u>
_____	_____
_____	_____
_____	_____

<u>Other Allergies</u>	<u>Reactions</u>
_____	_____
_____	_____

**Family Medical History**

Health Condition:

- Diabetes (Type 2)
- Heart Disease
- Heart Attack before 50
- High Cholesterol
- High Blood Pressure
- Obesity
- Stroke
- Asthma
- Thyroid Problems
- Bariatric Surgery
- Sleep Apnea
- Mental Health Problems
- Other:

Check the Family member(s) with the health condition:

- |                               |   |                                 |                                 |  |  |                                |
|-------------------------------|---|---------------------------------|---------------------------------|--|--|--------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |
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| <input type="checkbox"/> None | <input type="checkbox"/> Brother/Sister | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Mother's family | <input type="checkbox"/> Father's family | <input type="checkbox"/> _____ |

Does anyone in the family currently use any form of tobacco products?  Yes  No If yes, who: \_\_\_\_\_

**Psychological History**

Has your child ever been under the care of a psychiatrist, psychologist, therapist, or counselor?  Yes  No

If yes, who? \_\_\_\_\_ For what reason? \_\_\_\_\_

What has your child been diagnosed with (Circle all that apply) Learning Disorder \* Depression \* Anxiety \* ADHD \* None

Is there a family history of (Circle all that apply) Learning Disorder \* Depression \* Anxiety \* ADHD \* None

What concerns do you have about your child’s behavior, emotional or social functioning?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What else would you like the Healthy You for Life team to know about your child?

\_\_\_\_\_  
\_\_\_\_\_

**School**

What is your child’s current grade level? \_\_\_\_\_ Name of School \_\_\_\_\_

What concerns has your child’s teacher/school reported to you?

None  Academic  Social  Behavior  Attendance  Other: \_\_\_\_\_

What concerns do you have about your child at school?

None  Academic  Social  Behavior  Attendance  Other: \_\_\_\_\_

Present level of school performance:  Above Average  Average  Below Average

Is your child’s school performance:  Improving  Staying the same  Getting worse

Has your child been tested for special education services in school?  Yes  No

Is your child currently receiving special education services or have an IEP?  Yes  No

Has your child ever repeated a grade?  Yes  No Which grade(s): \_\_\_\_\_

**Activities**

Does your child have gym class at school?  Yes  No How often? \_\_\_\_\_ Do they participate?  Yes  No

Is your child in any after-school activities?  Yes  No If yes, please describe: \_\_\_\_\_

Is your child in any community, neighborhood, or religious programs that involve physical activity?  Yes  No

If yes, please describe: \_\_\_\_\_

What types of free time activities (active or sitting) does your child enjoy doing? \_\_\_\_\_

Are there any activities that your child would like to do but feels that they cannot (or will not) because of their current fitness level?  Yes  No

If yes, please describe \_\_\_\_\_

**Sleep**

Does your child have a regular bedtime and wake time?  Yes  No Comments: \_\_\_\_\_

Typical bedtime on school nights: \_\_\_\_\_ What time does your child usually wake before school? \_\_\_\_\_

Does your child have any problems at bedtime, or have any problems falling sleep at bedtime?  Yes  No

If yes, please explain: \_\_\_\_\_

Does your child have difficulty waking up in the morning?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child seem overly tired or sleepy a lot during the day?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child take naps?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child wake up a lot a night?  Yes  No Does your child sleepwalk or have nightmares?  Yes  No

Does your child have trouble getting back to sleep?  Yes  No Comments: \_\_\_\_\_

Does your child have loud or nightly snoring or have difficulty breathing at night?  Yes  No If yes, please explain: \_\_\_\_\_

Do you think your child is getting enough sleep?  Yes  No If no, please explain: \_\_\_\_\_

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**Children's Hospital of The King's Daughters, Healthy You Program -Informed Consent and Waiver**

*I understand that participation in an exercise program will involve risks and have consulted with my child's physician to assure that my child can participate in this program. These include, but are not limited to, a chance of heart attack, cardiac arrhythmia, fainting, and musculoskeletal problems.*

*To the best of my knowledge, except for conditions disclosed in this form, I know of no health condition that may adversely affect my child or me in safely participating in an exercise program.*

*I have read this document and I understand it. My child and I are participating willingly at our own risk. For my child, myself and anyone entitled to act on my child's behalf, I waive, release the YMCA, CHS, and CHKD from all liability and covenant not to sue or file administrative claims of any kind arising out of our participation in this program.*

Date \_\_\_\_\_

Print name \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

**Thank you for your time! We look forward to meeting you and your family.**

**The Healthy You Program Team**

**Fax to:  
(757) 668-7809**

**or**

**Mail to:  
Healthy You for Life Program  
c/o CHKD**

**601 Children's Lane  
Norfolk, VA 23507**