Healthy You for Life New Patient History Questionnaire

Patient Name:_____**DOB:**_____

Name of person filling out of form: _____ Relationship to patient: _____

Past Medical History: Chronic illnesses_____

Hospitalization_____**Surgeries**_____

Medications: _____

Allergies : _____

Under the care of a specialist, psychiatrist, psychologist, therapist or counselor? ___Yes ___No If yes, who_____

Circle all that apply: Learning disorder Depression Anxiety ADHD Bipolar None Other_____

Concerns about child's behavior, emotional or social functioning? ___Yes ___No If yes, why?_____

Social History : Home Life Stressors_____

School Information: Name of School: _____ Current grade: _____

Child's school performance and grades: Excellent Good Average Poor Repeat grades/concerns? _____

Nutrition: List typical foods eaten each meal

Eats breakfast? ___Yes___No Typical breakfast foods_____

Eats lunch? ___Yes ___No Typical lunch foods_____

Eats Dinner? ___Yes ___No Typical dinner foods_____

Snacks? ___Yes ___No Typical snacks?_____

Drinks? Typical drinks_____

Skips meals? ____Yes____No If yes, how often? Which meal(s)?_____

Activity:

Gym class at school? __ Yes __ No How often? _____ Do they participate? __ Yes __ No

After school activities? __ Yes __ No If yes, please describe:_____

Activiities your child enjoys: _____

Amount of Screen time per day:

Please circle types of electronics used: computer tablet iPad video games television cell phone

Hours per day of all devices: weekdays _____ weekends _____

Sleep routine: What is child's bedtime?_____ Awakes during the night? Yes_____ No_____

Time child gets up?_____ Takes naps? ____Yes ____No Falls asleep at school? ____Yes ____No

Falls asleep on car rides? ____Yes ____No

Circle all symptoms that your child is experiencing:

poor energy unusually tired during the day vision changes wheeze out of breath easily loud snoring apnea

abdominal pain constipation heartburn bedwetting if female: age of menses _____ regular or irregular?

thirst increased urination skin changes headache mood changes nervousness bullying

muscle aches joint or bone pain

Continue on reverse side and sign please.

Family History:

	Mother	Father	Sibling	Mother's mother	Mother's father	Father's mother	Father's father
Obesity/ overweight							
Diabetes							
High blood pressure							
High cholesterol							
Heart disease (heart attack, stroke)							
Depression							
Anxiety							
Learning disorder							
Thyroid problems							
Other							

Children's Hospital of The King's Daughters, Healthy You For Life 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 _____

Phone Number_____ Mailing Address _____

Thank you for your time! We look forward to meeting you and your family. The Healthy You for Life Team

Fax to: 757-668-7809 or Mail to: Healthy You for Life Program, 1924 Landstown Centre Way, Virginia Beach, VA 23456