

THE JOHNS HOPKINS WEIGHT MANAGEMENT CENTER
Pediatric Weight Management Program

This questionnaire is designed to obtain information about your overall health, weight and dieting history, eating and exercise habits, and other important factors. Feel free to use the margins or the back of a page to more fully answer a question. **Parents and children should try to fill out this application together. Please try to obtain a copy of your child's growth chart from your pediatrician or primary care physician and attach to this form.**

The information in these questionnaires will be reviewed with members of our clinical staff (dietitians, psychologists, exercise physiologists). Please be assured that all information that you provide will be regarded as strictly confidential and will only be available to the professionals on your treatment team.

Today's Date: _____

Name of person completing this questionnaire and relationship to child: _____

Child's Full Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Phone (Parent's Work) _____

Date of Birth _____ Age _____ Sex _____ Race _____

Today's Date _____ Email Address _____

Present Height _____ Present Weight _____

Estimated Weight 1 year ago _____

Age at which weight became a concern _____

1. Tell us who you live with:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Your mothers name and occupation _____

3. Your father's name and occupation _____

4. The school you attend and grade you are in _____

5. How well do you like school? great good fair poor

6. Do any of your family members have these problems? Please check yes or no and write their relationship to you (mother, father, grandparent, brother, etc.)

Overweight Yes No _____

Underweight Yes No _____

Bulimia/Anorexia Yes No _____

Diabetes Yes No _____

Stroke Yes No _____

Heart Disease Yes No _____

High Blood Pressure Yes No _____

High Cholesterol Yes No _____

Mood Problems Yes No _____

Alcohol/Drug Problems Yes No _____

Work Problems Yes No _____

Sleep Problems Yes No _____

BIRTH HISTORY:

Weight: _____ Length: _____ Full Term: Y/N

If not full term, how many weeks of gestation: _____

Diagnosis of Gestational Diabetes: Y/N

Breast Fed: Y/N How long? _____

Formula Fed: Y/N How long? _____

7. Has your child ever been in the hospital? If so, when and why?

8. Do you (child) want to change your weight? Y or N

9. If yes, why?

10. Have you ever tried to diet before? How old were you?

11. List some of your child’s favorite foods and drinks: _____

12. How do you feel about trying to change your eating (and exercise) habits? _____

Describe any changes that you have made recently _____

Do you feel happy about these changes? _____

13. Do you watch television? Yes _____ No _____
If yes, how many days per week? _____ how many hours per day? _____

14. Do you play video games? Yes _____ No _____
If yes, how many days per week? _____ how many hours per day? _____

15. Do you use the internet/play on the computer? Yes _____ No _____
If yes, how many days per week? _____ how many hours per day? _____

16. Describe current activities where you are being physically active. For example – playing with friends, sports you are involved in, classes you take, family activities?

17. Are there any activities that you used to do that you no longer participate in? If so, why not?

18. How does your child spend his/her free time?

EATING HISTORY AND STYLE:

19. How would you describe your child's appetite?

- good fair poor

20. What time of the day is your child most hungry?

- morning afternoon evening all the time

21. Is your child on a special diet? Y/N If yes, please describe _____

22. Do you consider your child to be a picky eater? Y/N

List any foods that are challenging for your child to eat? _____

23. How many days per week does your family eat meals together? _____

24. Does your child eat in front of the television or computer?

- always sometimes never

25. Do you eat in front of the television or computer?

- always sometimes never

26. How would you describe mealtimes together?

- always pleasant usually pleasant unpleasant

If unpleasant, please state why _____

27. How much 100% fruit juice does your child drink per day? _____ oz.

28. How much sweetened beverage, such as iced tea or soda, does your child drink each day? _____ oz.

List other beverages consumed during the day (be specific) _____

29. How many times per week does your child eat fast food? _____

From a full service restaurant? _____

Which restaurants? _____

30. Does your child skip meals? _____ If yes, which ones? _____

31. What is motivating you to seek treatment for your child's weight? _____

On a scale of 0 to 10, how *important* is it for you to help your child control his/her weight?

0	1	2	3	4	5	6	7	8	9	10
Not Important			Somewhat Important				Extremely Important			

If you decide to help your child change his/her weight, how confident are you that you could do it?

0	1	2	3	4	5	6	7	8	9	10
Not confident			Somewhat Confident				Extremely Confident			

On a scale of 0-10, how *ready and willing is the family* to try to make some changes now? (0= not ready, 10= very ready)

0	1	2	3	4	5	6	7	8	9	10
Not ready			Somewhat Ready			Extremely Ready				

32. Are there any habits that you, as a parent, would like to change to improve your own health?(please list) _____

Child's Current Medications: (list all, including name, frequency, and dose).

Child's Current Illnesses:

PHYSICIAN AND HEALTH CARE PROFESSIONALS INFORMATION:

(Please list all physicians, psychiatrists, or counselors currently involved in your child's health care).

(1) Full Name: _____
Address: _____
Phone Number: _____

(2) Full Name: _____
Address: _____
Phone Number: _____

THANK YOU FOR TAKING THE TIME TO PROVIDE THIS IMPORTANT INFORMATION.