Prana Health
Ad Vitam - For Life

Prana Health Weight Management Clinic
PEDIATRIC QUESTIONNAIRE

Patient information

Child's Last Name	First	Middle	Date of birth: (mm/dd/yyyy)

Your relationship to the child ☐ Biological mother ☐ Biological father ☐ Other	Referring Provider Information: Name: Address:	
Current Height (in)	Current weight (lbs)	Child's maximum weight (lbs): At what age :

Concerns about weight:

Please rate the following types of concerns about yoru child's weigh					
	Not at all	A little	Pretty much	A lot	Very much
Health issues at present	1	2	3	4	5
Teasing	1	2	3	4	5
Low Self esteem	1	2	3	4	5
Depression	1	2	3	4	5
Inadeqaute physical activity	1	2	3	4	5
Other	1	2	3	4	5

In your opinion, what factors are contributing towards your child's overweight? (Check all those apply)

☐ Eating too much ☐ Eating wrong type of foods ☐ Lack of exercise ☐ Genetics
☐ Too much TV ☐ Too much video games ☐ Hormones ☐ Medicines
☐ Others medical problems

Weight Loss Attempts

Has your child tried any weight loss diet or program		☐ **YES**		☐ **NO**
		Helped	Didn't help	
	Atkin's Diet			
	Committeed for Kids			
	Curves			
	Jenny Craig			
	Kidshape			
	Low Carb diet			
	Low Fat diet			
	South Beach			
	Weight Wacthers			
	Zone			
	Others			

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Has your child tried any weight loss medications or supplements		☐ **YES**		☐ **NO**
		Helped	Didn't help	
	Sibutramine (Meridia)			
	Phentermine (Adepex P)			
	Orlistat (Zenical)			
	Metformin			
	Metabolife			
	Herbal life			

What methods is your child currently trying to lose weight? (Check all those apply)

☐ Eating less ☐ Eating right type of foods ☐ Increasing exercise
☐ Cutting back on TV ☐ Cutting back on video games ☐ Diet plan ☐ Other

Past Medical History

Birth history: ☐ Early ☐ Late ☐ On time	Birth weight:	Breast fed until age:
Formula started at: ☐ Birth ☐ age_____ months	Formula stopped at what age	Started Cereals at what age
Any feeding problems at early age	☐ No	☐ Yes (explain)

Mother's medical problems during pregnancy:		Child's medical problems as newborn:	
☐ None	☐ Too little weight gain	☐ None	☐ Breathing problems
☐ Diabetes	☐ Too much weight gain	☐ Infection	☐ Floppy muscles
☐ High blood pressure	☐ Other	☐ Jaundice	☐ Poor growth

What are your child's current medical problems? (Check all those apply)

☐ ADHD ☐ Anemia ☐ Anorexia ☐ Anxiety ☐ Asthma ☐ Binge Eating ☐ Depression
☐ Diabetes ☐ Gastric reflux ☐ Heart problems ☐ High blood pressure ☐ High cholesterol
☐ Obstructive sleep apnea ☐ Polycystic ovary disease ☐ Sleep problems
☐ Vomiting to control weight ☐ Other

Current Medications and Supplements

_____

_____

_____

Allergies: _____

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Family History of significant medical problems

Mother's side:

☐ Overweight ☐ Cancer ☐ Anxiety
☐ Depression ☐ Diabetes ☐ Eating Disorders
☐ Heart problems ☐ High blood pressure ☐ High cholesterol
☐ Obstructive sleep apnea ☐ Polycystic ovary disease ☐ Sleep problems
☐ Substance abuse ☐ Weight loss surgery ☐ Other

Father's side:

☐ Overweight ☐ Cancer ☐ Anxiety
☐ Depression ☐ Diabetes ☐ Eating Disorders
☐ Heart problems ☐ High blood pressure ☐ High cholesterol
☐ Obstructive sleep apnea ☐ Polycystic ovary disease ☐ Sleep problems
☐ Substance abuse ☐ Weight loss surgery ☐ Other

Review of Systems (Check all those apply)

☐ Blurry vision ☐ Headaches ☐ Nasal congestion ☐ Snoring ☐ Pauses in breathing ☐ Acne
☐ daytime sleepiness ☐ Excess hair growth ☐ Vomiting ☐ Chest pain ☐ Bedwetting
☐ Darkening of skin on the neck, underaras or around the waist ☐ Shortness of breath
☐ Breast elargement apart from normal development ☐ Irregular menstrual periods ☐ Hip pain
☐ Recent unintended weight loss ☐ Behavioral problems ☐ Knee pain
☐ Sleep problems ☐ Other

Eating and Physical Activity

How many times does your child:	2-3 times /day	1 times /day	2-3 times /week	1 time/ week	2-3 times /month
Eat at fast food Restaurants					
Eat at other Restaurants					
Eat /drink from Vending Machines / Food Stands/Ice-cream truck					
Drink Sodas or other similar drinks					
Drink Juice					
Drink Milk					
Eat fruit					
Eat vegetables					
Eat breakfast					

Does the family have meals together at home				
Never	Hardly ever	Sometimes	Mostly	Always
1	2	3	4	5

Does the child participate in sports activities?

☐ None ☐ Baseball ☐ Basketball ☐ Football ☐ Tennis ☐ Soocer ☐ Other

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Screen time

How many hours PER DAY your child participate in the following activities		
	During the week	During the weekend
Watching TV/Video		
Playing Video Games		
Using computer		
Is the TV on during dinner	☐ **No**	☐ **Yes**
Does the child have TV in their bedroom	☐ **No**	☐ **Yes**

DEPRESSION SCREEN (ONLY FOR CHILDREN> 12 years old)

1. **Over the *last 2 weeks,* has the child been bothered by any of the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching tv.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ADD COLUMNS: _____ + _____ + _____ + _____

TOTAL: _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the las 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the day	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____	_____	_____	_____

Total Score =_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____

Somewhat difficult_____

Very difficult_____

Extremely difficult_____

DATE:

Parent's Signature_____