CENTRA

Centra Weight Loss Clinic
Initial Appointment Questionnaire - Pediatric

***Please note: To provide appropriate care forms MUST be completed prior to initial visit.**

Patient Information	**Name**	**Date of Birth**	**Gender** (circle one) **Male - Female**
Address / City / State / ZIP			
Home Phone	**Cell Phone**	**Work Phone**	
May we leave a voicemail Y/N	**May we text you Y/N**	**May we email you Y/N**	
E-mail address	**Marital Status** Single - Married - Divorced - Widow - Other		
Employer (if applicable)	**Spouse's Employer (if applicable)**		
Parent or Guardian (Name and Date of Birth)	**Parent or Guardian (Phone and Relationship)**		
Emergency Contact (Name and Date of Birth)	**Emergency Contact (Phone and Relationship)**		
Referral Source (circle one) Family/Friend - Physician - Website - Web ad - Radio/TV ad - Print ad - Insurance company - Other:_____			
Physician Name (if referred)			
Physician Office/Specialty			

The information provided is correct to the best of my knowledge. My signature below authorizes CENTRA to communicate with me via email, phone, or other means indicated.

Signature*: _____ **Date:** _____

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Physician Information	**Primary Care Physician (Name)**	
Location (city, state)	**Date of last visit**	**Date of next visit**
Have you had lab tests in the last 3 months? Yes No (If yes, please bring them to your initial visit or notify us so we may request these results.)		

Pharmacy Information	**Preferred Pharmacy**
Location (city, state)	**Phone number**

Insurance Information	**Policyholder Name (if other than patient)**	
Primary Insurance (i.e. BC/BS, Aetna, etc.)		**Primary Insurance Phone #**
ID / Policy Number	**Group Number**	
Secondary Insurance Policyholder Name (if other than patient)		
Secondary Insurance (if applicable)		**Secondary Insurance Phone #**
ID / Policy Number	**Group Number**	

The information provided is correct to the best of my knowledge. My signature below authorizes CENTRA to communicate with me via email, phone, or other means indicated.

Signature (parent/guardian)*: _____Date: _____

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Medical History	You may not be familiar with some terms, but mark all that apply.		
CONDITION	**MANAGEMENT** (Check all that apply)	**CONDITION**	**MANAGEMENT** (Check all that apply)
☐Type 2 Diabetes	□ Diet controlled □ Oral Medication □ Insulin	☐Heart Disease (type:_____)	□ Medication □ Hospitalization
☐Hypertension (High Blood Pressure)	□ Diet controlled □ Medication Usual reading: _____ / _____	☐Coronary Disease (Heart Attack, Angina)	□ Medication □ Stents: _____ □ Bypass surgery
☐High cholesterol (Hyperlipidemia)	□ Diet controlled □ Medication	☐Liver Disease *(type:_____)*	
☐Obstructive Sleep Apnea	□ Using CPAP □ CPAP prescribed, not used □ Using mouth spacer	☐Kidney Disease	□ Medication □ Dialysis
☐Gastroesophageal Reflux (GERD, heartburn)	□ Diet controlled □ Medication	☐ Asthma	□ Medication □ Frequency of inhaler use: _____
☐Arthritis / Joint Pain	□ Physical therapy □ Prior surgery	☐☐Cancer *(Type:)*	□ Active treatment?
☐ Birth defects/Syndromes (type:_____)	□ Active monitoring? □ Medication	☐ Suicidality	□ Currently □ Only in past
☐Depression	□Therapy / counseling □ Medication	☐ Irregular Menstrual Cycles (if applicable)	□ Active monitoring? □ Medication
☐ Polycystic Ovaries	□ Medication	☐ Thyroid disease	□ Medication □ Prior thyroid surgery
☐Other:		☐Other:	

Birth History	Gestational Age at Birth: ☐Full Term ☐Pre Term (weeks: _____) ☐Post Term (weeks: _____)
Birth Weight: _____	Breastfed? ☐No ☐Yes, how long: _____
Infant complications after during pregnancy or after birth? ☐No ☐Yes; explain:	
Maternal complications during pregnancy? ☐No ☐Yes; explain:	

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Surgical History	You may not be familiar with some terms, but mark all that apply. Add anything not listed.	
SURGERY TYPE	**APPROACH**	**YEAR**
☐Appendix (appendectomy)	□ Laparoscopic □ Open □ I don't know	
☐Gallbladder (cholecystectomy)	□ Laparoscopic □ Open □ I don't know	
☐Hysterectomy	□ Laparoscopic □ I don't know □ Open □ Vaginal	
☐Previous bariatric surgery *List type:*	□ Laparoscopic □ Open	*Hospital:*
☐Other *List type:*		
☐Other *List type:*		
☐Other *List type:*		

Medications	List all current medications or attach up-to-date and current list.		
MEDICATION	**DOSE**	**SCHEDULE**	**PURPOSE**
Example only: *Metformin*	*500mg*	*1 pill twice a day*	*diabetes*

NAME: _____ DATE: ____/_____/_____ DATE OF BIRTH: _____/_____/_____

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Allergies	List all medication/food allergies or indicate: ☐ *I have no known allergies.*

MEDICATION NAME	REACTION

Social History	Fill out everything to the best of your knowledge. ☐ Check if "NO" for entire section.			
TOBACCO USE	Do you smoke? YES - NO	Did you ever used to smoke? YES - NO I quit in _____ *(yr)*	Packs/day: _____ Years: _____	Willing to quit? YES - NO
ALCOHOL USE	Do you drink? YES - NO	_____ drinks per week of *(circle)* beer / wine / liquor		
SUBSTANCE USE	Do you or have you use(d) any of the following: □ Marijuana □ Ecstasy □ Heroin □ Meth(amphetamines) □ Cocaine □ Other:_____			

Review of Body Systems	Mark *all symptoms* that you are ***currently*** experiencing.		
GENERAL	□ Fevers or chills □ Loss of appetite □ Excessive sweating □ Trouble sleeping	**URINARY**	□Pain with urination □Kidney stones □Trouble starting/stopping stream □Leakage (incontinence)
EYES	□ Burning / irritation □ Change in vision □ Double vision	**SKIN / BREAST**	□ Skin lesion (new) □ Rash □ Changing mole □Breast lump (new)
EARS / NOSE / THROAT	□ Earaches □Nasal congestion □ Ringing in ears □Cough □ Nosebleeds □Sore throat	**HEMATOLOGIC**	□Easy bruising □Prolonged bleeding □Swollen glands
RESPIRATORY	□Wheezing □Pneumonia □Shortness of breath □ Asthma	**MUSCULOSKELETAL**	□Back or neck pain □Painful joints: _____ □Muscle aches □Muscle weakness
CARDIOVASCULAR	□Chest pain □Chest pressure □Palpitations / irregular heartbeats	**NEUROLOGICAL**	□Numbness or tingling □Seizures □Headaches □Dizziness / vertigo
GASTROINTESTINAL	□Nausea / vomiting □Constipation □ Acid reflux □Diarrhea (heartburn/GERD) □Abdominal pain	**SLEEP**	□Snoring loudly (witnessed) □Fatigue during daytime / nodding off

NAME: _____ DATE: ____/_____/_____ DATE OF BIRTH: _____/_____/_____

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Obesity History	1. First considered OVERWEIGHT at was age?	2. Family History of Overweight/Obesity? YES NO If yes, who?
2. Reason(s) for weight gain?		
3. How does your weight currently limit you?		
4. Have you ever been (or are you now) "picked-on" or "bullied" because of your weight?		
7. What do you see as your 2 biggest barriers to losing weight?		
8. What are at least 2 benefits of weight loss for you?		

Sleep Assessment	1. How much sleep do you get at night, on average?
2. Do you feel rested when you wake up in the morning?	
3. Has anyone told you that you stop breathing during your sleep?	
4. How likely are you to fall asleep or doze in the following situations (NOT just feeling tired)? Use the scale below to choose the most appropriate number for each situation: 0 – No chance of dozing 1 – Slight chance of dozing 2 – Moderate chance of dozing 3 – High chance of dozing	

SITUATION	CHANCE OF DOZING	SITUATION	CHANCE OF DOZING
Sitting and reading		Lying down to rest in the afternoon (when able)	
Watching TV		Sitting and talking to someone	
Sitting inactive in a public place (theater or meeting)		Sitting quietly after lunch without alcohol	
As a passenger in a car for 1 hour without a break		In a car, while stopped for a few minutes in traffic	

Activity History	1. Do you have any limitations or injuries that make exercise difficult? Explain.
2. How many minutes of exercise or "active play" do you engage in per day?	
3. How many minutes of total "screen time" do you have per day (TV, internet, games, etc. Do not include required school activities done on computer)?	

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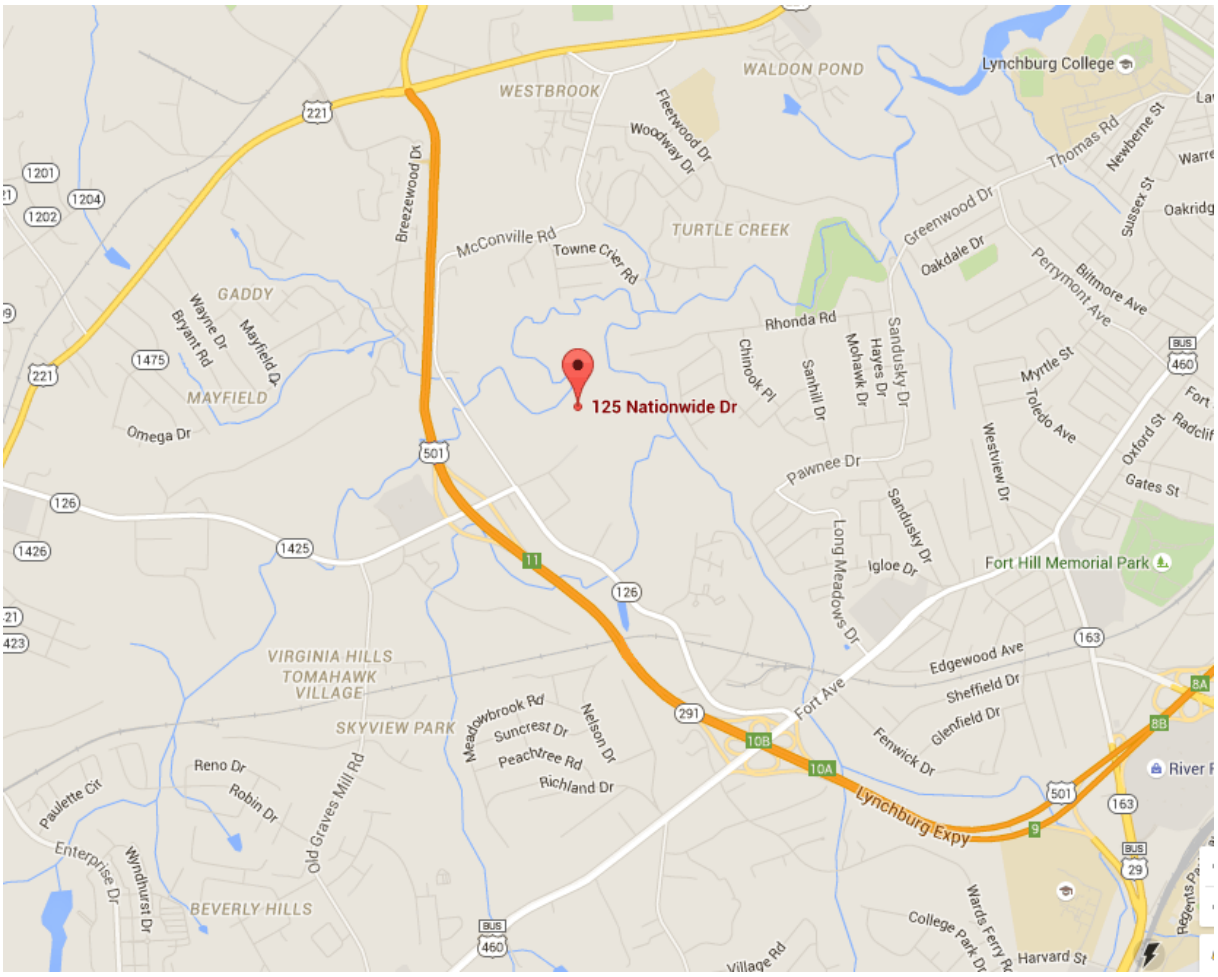
Upon completion, submit this information packet either *in person* or *by mail* to:

Centra Weight Loss Clinic (Administration)
125 Nationwide Drive
Lynchburg, VA 24501

We want to safeguard your personal information as best we can. Please do not email or fax this packet. We will contact you after receiving your packet.

Clinic appointments will be held at:

Centra Weight Loss Clinic
125 Nationwide Drive
Lynchburg, VA 24502



You may keep this sheet as a reference.

NAME: _____ DATE: ____/_____/_____ DATE OF BIRTH: _____/_____/_____