Allina Health Weight Management - Kids and Teens Program

Welcome! Thank you for choosing Allina Health Weight Management. The Kids and Teens program has many weight loss options, and we will work with you to find the right one for you.

Please complete the health history form so the team can be ready to work with your family on the day of your appointment.

Kids and Teens Weight Management Program

The Kids and Teens program is a resource for kids, teens, and young adults to achieve a healthier weight. Families and patients work with a team of doctors, dietitians, mental health providers, physical therapists and other specialists.

Family involvement is important. Parent support of changes in the home environment are important for improved weight and health of the child. We welcome parents, caregivers and siblings to come to clinic visits.

The first clinic visit takes time. You can expect to be in clinic for 3 to 4 hours. During that time, families will meet with the doctor, dietitian, psychologist, physical therapist and nurse. Please note: If it is easier for your family to space these appointments out, please let us know. We are happy to schedule appointments to meet the needs of your family.

During the first visit you can expect:

Doctor – the doctor will complete a medical evaluation and create an individual treatment plan. The treatment plan will include visits with the psychologist, and possibly, referrals to other medical specialists.

Dietitian – the dietitian will look at current eating habits and overall nutrition to create a meal plan that supports child and family goals.

Physical therapist – the physical therapist will look at current level of activity and movement to see if excess weight has had an effect on the child's growth and development. The therapist will recommend a safe and effective plan for physical activity.

Surgeon – in some adolescent patients, after 6 to12 months of intensive, medically supervised weight management efforts, the team, patient and family may determine that they are more appropriately treated with an operation. A consultation may be recommended with the bariatric surgeon.

For additional support in talking with your child about weight and health: www.weighinonobesity.org

INSURANCE VERIFICATION FORM
Kids and Teens Program

You must contact your insurance company to determine your coverage for weight loss services. To do so, please call the customer service number on the back of your insurance card. Keep record of the date of your call as well as the name of the customer service representative who provided you the information.

Your Name: ____ **Date of Birth:** ____ /____ /____

Have you had weight loss surgery in the past? ☐ **Yes** ☐ **No**

INSURANCE INFORMATION

Primary Insurance:

Company: ___________________________________/**ID#** ________________ **Group#** ___________

Secondary Insurance (If applicable):

Company: ___________________________________/**ID#** ________________ **Group#** ___________

If UCARE Insurance, what is the PMI number: ____

Are you the subscriber: ☐ **Yes** ☐ **No**

If not, Name of Subscriber, Date of Birth, and Relationship

____/_______________/__________________

Social Security Number of Subscriber: ____________________ **(Tricare and Veterans Insurance ONLY)**

Provider Phone Number OR Customer Service Phone Number on the back of your insurance card: _______________________

We will document the information we receive in your Excellian Chart. This will be provided to your nurse clinician prior to your Initial Visit so that she can accurately determine a plan of care for you to meet your specific insurance criteria. If we determine that you **DO NOT have insurance coverage for weight loss services**, we will contact you. Please provide the best phone number to reach you and also indicate if we are able to leave a message for you at that phone number.

Be aware that Medicare and Medicare replacement plans do not cover dietitian visits. Medicare enrollees may be asked to sign a waiver acknowledging these visits may not be a covered service. Initials ______

Phone: ____________________ **Okay to Leave a Message:** ☐ **Yes** ☐ **No**

For Office Use Only:

Location: ANW STF UTD UTY

Provider: _______________________

Date of Visit: ____________________

Office Use Only:
Date Rcvd: ____________________
MRN: ____________________
Approval: ____________________
EE: ____________________
PKG: ____________________
Appts: ____________________
IDEA: ____________________
Excellian: ____________________

Stop Bang ____________
Ins ____________

Doc Type: Questionnaire
Descriptor: Bariatric

Kids, Teens and Young Adults Health History Form

Date: ____________________

Please bring the records from your most recent doctor visit with you when you come to your Weight Management appointment.

Patient's Name: ______________________________ Date of Birth: ____________________ Age: ________

Address: __________________________ City: ____________________ State: ______ Zip Code: __________

Parent / Legal Guardian: ____

Person Completing Form: ________________________ Relationship to Patient: ________________________

Emergency Contact: ____________________________

Phone Number: ____________________ Email: ____________________________________

What is the patient's preferred language? ____________ What is the caregiver's preferred language?____________

Would you like the clinic to provide an interpreter? ☐ Yes ☐ No

Weight History

Current height?	Current weight?
BMI / Percentile (This will be calculated by staff)	
At what age did the patient first become overweight?	
Average weight over the past 5 years	

Pattern or known causes of weight gain?

☐ Since infancy

☐ Gradual over time

☐ Postpartum

☐ Depression or other significant life event Describe: ______________________________

☐ Medication related. Name of medication(s): ______________________________

☐ Sudden / unexpected Explain: ______________________________

☐ Other: ______________________________

Weight Loss History

Weight Loss Attempts – Indicate which diet programs tried in the past

Diet Program	Dates	Pounds lost
Atkins diet		
Cabbage soup		
Calorie counting		
Diabetic diet		
Exercise		
Grapefruit		
Jenny Craig		
LA Weight Loss		
Low fat / low cholesterol		
Physician supervised program		
Medifast		
New Day		
Nutrisystem		
Other high protein / low carbohydrate		
Optifast		
Overeaters Anonymous		
Own reduced calorie / portions		
Registered Dietitian visits		
Slimfast		
Slimgenics		
South Beach		
TOPS		
Weight Watchers		
Zone		
Other		

Weight Loss Medications – Indicate which medications the patient has used to lose weight

Medication	Dates	Pounds lost
lorcaserin (Belviq)		
metformin (Glucophage)		
naltrexone HCL/Buproprion HCL (Contrave)		
orlistat (Alli, Xenical)		
phentermine		
phentermine / topiramate (Qsymia)		
sibutramine (Meridia)		
topiramate (Topamax or Trolandi)		
bupropion (Wellbutrin)		
liraglutide (Saxenda)		
Other:		

	Yes	No
Has the patient tried diet and exercise for a period of at least 6 months?		
Has the patient tried diet and exercise for a period of at least 3 months?		
Did you lose 1 pound or more a week while trying diet and exercise?		

Dietary Assessment

What time do you:		Dietary recall:
Wake up?		How many meals does the patient eat each day?
Eat breakfast?		How many times does the patient snack each day?
Eat lunch?		How many cups of fruit does the patient eat each day?
Eat dinner?		How many cups of vegetables does the patient eat each day? Do not include corn and potatoes
Eat snacks?		
Go to bed?		

Describe what the patient typically eats for each of the following:

Breakfast	
Lunch	
Dinner	
Snacks	

Nutritional History

What are the patient's nutrition and health goals?	
Is there anything that holds the patient back from attaining his or her health and nutrition goals?	
What, if anything has the patient tried in the past to manage his or her nutrition related concerns?	

Food Preferences

Is the patient following a special diet? Does he or she have specific dietary limitations or needs based on health, ethnic, cultural, or religious preferences?	☐ Yes	☐ No	Please explain:

Please list:	Food Allergies	Sensitivities	Intolerances	Food Cravings	Food Dislikes

Which dietary choices or habits do you feel the patient is most challenged by?	
Who is involved in preparing food for and feeding the patient?	☐ Self ☐ Parent ☐ School ☐ Daycare ☐ In-Home Care ☐ Grandparent
Who does the food shopping for your household?	
Where is food shopping done?	

Dining Out History:

How many times does the patient eat out each week?	
Where does the patient eat out?	
What foods does the patient order when eating out?	

Describe what the patient typically consumes for liquids:

	Type	Amount in ounces	per day	per week	per month
Alcohol					
Diet soda					
Regular soda					
Milk					
Juice					
Water					
Artificially sweetened water					
Other					
Coffee	☐ caffeine ☐ decaf				
Sugar	How much:				
Cream	How much:				
Tea	☐ caffeine ☐ decaf				
Sugar	How much:				
Cream	How much:				

Meal Activity:

How long does it take the patient to eat a meal?	
How often does the patient skip meals?	
When at home, where does the patient eat meals and snacks?	

	Yes	No	Comment
Does the patient do any binge eating?			
Does the patient eat until uncomfortably full?			How often?
Does the patient eat when not physically hungry?			
Does the patient or caregiver worry that they have loss of control over how much eaten?			
Does the patient wake at night to eat?			

Physical Activity

Indicate **past** exercise efforts:

☐ group exercise classes	☐ health club membership (YMCA, Curves, SNAP Fitness, etc.)
☐ use of a pedometer / fitness tracker	☐ home exercise (videos, treadmill, etc.)
☐ personal trainer	☐ other – describe:

Describe **current** exercise program:

Type of exercise	
Frequency (number of days per week)	
Duration (number of minutes per session)	
If **not** exercising, what keeps the patient from exercising?	

Ability to Walk:

☐ no limitations	☐ Use of a brace	☐ Use of a cane	☐ Use of a walker	☐ Use of a Wheelchair
Able to walk 2 blocks?		☐ Yes ☐ No		
Able to go up and down a flight of stairs?		☐ Yes ☐ No		

Allergies

List allergies to medicine, food, dye, tape, metal, latex.

Allergy	Reaction

Medications

List **all current** medications including vitamins, over-the-counter medications, supplements, and intermittently used medications (or attach a current list).

Name	Dose	How often taken	Purpose	Year started

Pharmacy of Choice – name the pharmacy used to have prescriptions filled.

Name of pharmacy	City/Location	Phone Number

Pregnancy/Birth History

At what week in the pregnancy was the patient born?		
During pregnancy, did the patient's birth mother have:	Gestational Diabetes? ☐ Yes ☐ No Obesity? ☐ Yes ☐ No High Blood Pressure? ☐ Yes ☐ No	
Were there any other problems during the pregnancy?	☐ Yes	☐ No Explain:
Were there any problems during the delivery?	☐ Yes	☐ No Explain:
☐ Vaginal Delivery ☐ C-Section		
Were there any special problems soon after the birth?	☐ Yes	☐ No Explain:
Normal State Newborn Screen	☐ Yes	☐ No Explain:
Birth Weight _______________		
Breast Fed?	☐ Yes	☐ No How long?

Medical History

Has the patient every been **diagnosed** with any of the following:

Cardiovascular	Respiratory	Musculoskeletal	Endocrine
☐ irregular heart beat	☐ asthma	☐ rheumatoid arthritis	☐ diabetes type I
☐ heart block	☐ obstructive sleep apnea	☐ degenerative disc disease (DDD)	☐ diabetes type II
☐ pacemaker/palpitations	☐ pulmonary hypertension		☐ pre-diabetic
☐ chest pain (angina)	☐ emphysema/COPD	☐ degenerative joint disease (DJD) / osteoarthritis where:	☐ diabetic eye problems
			☐ impaired fasting glucose
☐ heart disease	☐ pulmonary embolism		☐ diabetic ulcers
☐ congestive heart failure	**Liver/Stomach/Intestine**	☐ herniated disc	☐ low thyroid (hypothyroid)
☐ heart attack (MI)	☐ gallstones	☐ gout	☐ infertility
☐ high blood pressure	☐ inflamed gallbladder	☐ carpel tunnel syndrome	☐ hypoglycemia
☐ coronary artery disease	☐ hepatitis	☐ plantar fasciitis	☐ metabolic syndrome
☐ carotid artery disease	☐ ulcer	☐ Scoliosis	☐ morbid obesity
☐ edema	☐ h. pylori	☐ Slipped capital femoral epiphysis	☐ obesity
☐ high triglycerides	☐ colitis		☐ pancreatitis
☐ high LDL cholesterol or low HDL	☐ spastic colon	☐ Blant disease	**Reproductive/Male**
	☐ irritable bowel	**Neurological**	☐ penile deformity
☐ heart murmur / abnormal heart valve	☐ Crohn disease	☐ seizures	☐ cryptorchidism
	☐ acid reflux or heartburn (GERD)	☐ migraines	
☐ pass out or lose consciousness		☐ neuropathy/nerve pain	**Other**
	☐ fatty liver (NASH or NAFLD)	☐ sciatica	☐ awaiting organ transplant – type:
☐ blood clot or DVT	☐ increased LFT's	☐ pseudotumor cerebri	☐ glaucoma: open angle
Kidneys / Genitourinary	**Infectious Diseases**	☐ narcolepsy/drop attacks	☐ glaucoma: narrow angle
☐ renal insufficiency	☐ VRE	☐ paralysis	☐ glaucoma: unknown
☐ diabetic kidney disease	☐ MDRO	☐ restless leg syndrome	☐ other eye problem
☐ kidney failure	☐ MRSA	☐ fibromyalgia	☐ history of cancer
☐ currently on dialysis	☐ C Diff	☐ multiple sclerosis	☐ genetic disorder
☐ stress incontinence	☐ HIV positive	☐ stroke/CVA	☐ developmental delay
☐ kidney stones	**Skin**	☐ Charcot Marie Tooth Syndrome	☐ learning disability
	☐ problems with healing of wounds/cuts/bruises		

Mental Health

Has the patient ever been diagnosed with:

	Yes	No	Date of diagnosis	Treatment
Autism				
ADHD				
Depression				
Bipolar				
Anxiety / Panic attacks				
Schizophrenia				
Psychosis				
Personality disorder				
Compulsive overeating				
Anorexia Nervosa				
Binge eating disorder				
Bulimia				
Other / describe				

Check all that apply:

	Yes	No	Comment
Thoughts of self harm (now or in the past)			
Past suicide attempt			
Under the care of a psychiatrist			Provider name: Duration of treatment:
Under the care of a counselor or therapist			Provider name: Duration of treatment:

Has the patient taken anti-depressants, anti-psychotics, stimulants or ADHD medication before?

Name of Medicine	Prescribed by	Month/Year Taken	Condition	Dosage and Length of Treatment

Has the patient had any of the following? tests/evaluations:	Yes	Date	Name of facility or health system	Result/Explanation
EKG?				
echocardiogram? (ultrasound of heart)				
stress test?				
other heart tests?				
sleep study (or screening for sleep apnea)				Treatment?
upper endoscopy procedure(s) (EGD)?				
colonoscopy?				
thyroid test?				
Hgb A1c?				
EEG/qEEG				

Female Reproductive

Age at time of first period? ________

After the first year, menstrual periods have been (check all that apply)		
☐ Regular, periods every ______ weeks	☐ Irregular	☐ Heavy flow/many clots
☐ Normal flow	☐ Not applicable, explain	

	Yes	No	
Does the patient use birth control?			What method?
Is there a **possibility the patient is pregnant**?			
Has the patient ever been pregnant?			If yes, explain:
Does the patient have polycystic ovarian syndrome (PCOS)?			
Any breastfeeding in the past six months?			

Dental Problems

	Yes	No
Does the patient have dentures or partials?		
Ever been diagnosed with TMJ?		
Does the patient have trouble chewing?		
Does the patient have trouble swallowing liquids, pills or solids?		
Had wisdom teeth removed?		
Have missing teeth?		

When was the patient's last dental visit?	Date:

Surgical History

Surgery	Year	Incision location	Reason

	Yes	No	Comment
Has the patient had problems with anesthesia?			
Has the patient ever had a blood transfusion?			When:

Weight Loss Surgery – complete this section **ONLY** if the patient has had weight loss surgery before.

	Comments
What year was weight loss surgery?	
Name of surgeon:	Where:
Weight before surgery:	Lowest weight after surgery: (_____ months postop)
Any adverse events after surgery?	Describe:

Indicate type of operation:

☐ gastric bypass (Roux-en-Y)	☐ adjustable gastric band (Lap-band or Realize band)
☐ duodenal switch	☐ vertical banded gastroplasty (VBG)
☐ sleeve gastrectomy	☐ Other:

Family History

	Age now or at death	Cause of death	Cancer – (include type)	Coronary Artery Disease – type and age of onset	Diabetes Type? I, II, Gestational	High cholesterol	High blood pressure	Obesity BMI >30 or >95% children	Bleeding or Clotting Disorder (specify)
Mother									
Father									
Brother/ Sister									
Brother/ Sister									
Brother/ Sister									
Maternal GrandMa									
Maternal GrandPa									
Paternal GrandMa									
Paternal GrandPa									

Review of Systems

Check off any symptoms the patient **currently** has:

General	Cardiac	Musculoskeletal	Male Genital/Urinary
☐ fatigue	☐ chest pain	☐ low back pain	☐ incontinence
☐ fevers	☐ fast heart rate	☐ neck pain	☐ blood in urine
☐ chills	☐ irregular heart rate	☐ muscle pain	☐ difficult urination
☐ insomnia	☐ lightheadedness	☐ joint pain – location:	☐ impotence
☐ excessive daytime sleepiness or drowsiness	☐ fainting or passing out		☐ erectile dysfunction
	☐ none of the above	☐ muscle or joint stiffness	☐ none of the above
☐ none of the above	**Gastrointestinal**	☐ mobility problems	
Head and Neck	☐ heartburn	☐ use of cane or walker	**Female Genital/Urinary**
☐ TMJ Symptoms	☐ constipation	☐ none of the above	☐ stress incontinence
☐ recent dental problems	☐ diarrhea	**Skin**	☐ menstrual irregularity
☐ none of the above	☐ IBS Symptoms	☐ acne	☐ heavy menses
Eyes	☐ lactose intolerance	☐ recurrent skin infections	☐ blood in urine
☐ change in vision	☐ wheat intolerance	☐ skin tags	☐ excessive facial hair
☐ eye pain	☐ hemorrhoids	☐ stretch marks	☐ none of the above
☐ none of the above	☐ stool incontinence	☐ dark skin on neck or armpits (acanthosis nigricans)	**Neurological**
Respiratory	☐ abdominal pain		☐ seizures
☐ shortness of breath at rest	☐ Nausea/vomiting		☐ tremors
☐ shortness of breath with activity	☐ none of the above	☐ none of the above	☐ headaches
	Psychological	**Vascular**	☐ migraine headaches
☐ cough	☐ excessive worry	☐ swelling of lower extremities	☐ tension headaches
☐ snoring	☐ anxiety		☐ balance problems
☐ waking up due to snoring or stopping breathing	☐ panic attacks	☐ ulcers of lower extremities	☐ walking problems
	☐ depression		☐ nerve pain
☐ none of the above	☐ feeling "up" or elated	☐ none of the above	☐ numbness/tingling
	☐ none of the above		☐ none of the above

Sleep Apnea Screen

Has the patient been screened, diagnosed, or treated for sleep apnea? ☐ Yes ☐ No

Details: ____

Average hours of sleep per night __________

Does the patient have current bedwetting? ☐ Yes ☐ No

Collar size of shirt: ☐ S ☐ M ☐ L ☐ XL or ____________ inches cm

	Yes	No
Snoring - Does the patient snore loudly (louder than talking or loud enough to be heard through closed doors?)		
Tired - Does the patient often feel tired, fatigued, or sleepy during the day?		
Observed - Has anyone observed the patient to stop breathing during sleep?		
Blood Pressure - Is the patient being treated for high blood pressure?		
BMI - BMI more than 35 kg/m^2		
Age - Age over 50 years old?		X
Neck circumference - Neck circumference greater than 40 cm/15.75 inches		
Gender - Gender male?		

Weight Management - Kids and Teens Program Health History Form

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PATIENT LABEL

Social History

Does the patient attend daycare?	☐ Yes	☐ No	Is the patient in a relationship? ☐ Male ☐ Female ☐ Both	☐ Yes	☐ No
Does the patient attend preschool?	☐ Yes	☐ No			
Does the patient attend school?	☐ Yes	☐ No	☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ College		
As a caregiver how do you learn best?	☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures				
As a caregiver do you have any learning difficulties or barriers to learning?	☐ Yes	☐ No	If yes, please specify:		
How does the patient learn best?	☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures				
Does that patient have any learning difficulties or barriers to learning?	☐ Yes	☐ No	If yes, please specify:		
The patient typically goes to bed at:			The patient typically wakes at:		
The patient typically gets _______ hours of sleep per night					
Comments:					
The patient's favorite activities are:					

The patient is involved in the following exercise activities or sports	Activity	Frequency:	Duration:
	Activity	Frequency:	Duration:
	Activity	Frequency:	Duration:
Average screen time per day __________ minutes/hours	(Check one) ☐ television ☐ computer ☐ smartphone ☐ video game		

Is the patient employed?	☐ Yes	☐ No	Describe work	Hours/week

	Yes	No	Type/Amount/Frequency
Does the patient currently use tobacco?			
Is the patient exposed to tobacco?			
	Yes	**No**	**Type/Amount/Frequency**
Does the patient consume alcohol?			
	Yes	**No**	**Type/Amount/Frequency**
Has the patient ever used street drugs?			
Is the patient exposed to street drugs?			

	Yes	No	Type / Treatment
Does the patient have a history of chemical dependency?			
Is there a family history of chemical dependency treatment?			When:

Readiness to Change

This exercise will help you understand how ready the patient is to change certain behaviors related to health and well-being. The answers will help your team determine what areas of health are most important, as well as help set realistic goals. Please do not judge team answers, just try to be as truthful as possible. There are no right or wrong answers.

In the first column, **rank on a scale of 1-10 how important the following behaviors are to you** (1 = not important at all and 10 = very important). If the behavior is not applicable (i.e. you do not smoke), just write "NA" in the box. Keep in mind; something can be important to us, even if we struggle to change the behaviors. If you think about something often, chances are it is important to you.

In the second column, **rank on a scale of 1 – 10 how confident you are that you can make and maintain changes in these areas** (1 = not confident at all and 10 = very confident/already part of my lifestyle).

BEHAVIOR	IMPORTANCE	CONFIDENCE
Reduce / cease smoking		
Weight management		
Physical activity		
Nutrition		
Stress management		
Medication compliance		
Sleep		

1 = not important 1 = not confident

10 = very important 10 = very confident

NA = not applicable

Medical Care Providers

List all current care providers, starting with primary care provider. Include the area of specialty, addresses, and phone numbers, conditions treated, and length of time seeing this provider:

Primary Care Provider Name: ______________________ Clinic: ______________________

Address: ______________________ Phone: ______________________

Specialty: (check one) ☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ Other: ______________________

How long with this provider? ______________________

Provider Name: ______________________ Clinic: ______________________

Address: ______________________

Specialty: ______________________ Phone: ______________________

Conditions Treated ______________________ How long w/provider? ______________________

Provider Name: ______________________ Clinic: ______________________

Address: ______________________

Specialty: ______________________ Phone: ______________________

Conditions Treated ______________________ How long w/provider? ______________________

Provider Name: ______________________ Clinic: ______________________

Address: ______________________

Specialty: ______________________ Phone: ______________________

Conditions Treated ______________________ How long w/provider? ______________________

Did a medical provider refer you to our program? ☐ Yes ☐ No

If yes, who referred you? ______________________