Patient History Questionnaire

Patient Name:_____DOB:_____

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

Past Medical History: Chronic illness_____Hospitalization_____Surgeries_____

Social History : Home Life Stressors_____

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

Repeat grades? __ Yes __ No If so, what grade? _____

Child's school performance and grades: Excellent Good Average Poor

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

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

Is there a *family h*istory of (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?_____

Excessive absences from school? __ Yes __ No If yes, why?_____

Problems at school? __ Yes __ No If yes, why?_____

Any school suspensions? __ Yes __ No If yes, why?_____

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 snack?_____

Drinks? Typical drinks_____

Skips meals? ____Yes____No If yes, how often?_____

Exercise:

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

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

Amount of Screen time per day:

Computer/ipad	less than 2 hours a day	2 – 6 hours a day	over 6 hours a day	none
TV	less than 2 hours a day	2 – 6 hours a day	over 6 hours a day	none
Cell phone	less than 2 hours a day	2 – 6 hours a day	over 6 hours a day	none

Bedtime 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

Continue on reverse side and sign please.

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