Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | **Language** ☐ English Other: _____

Race (circle one) African American/Black | American Indian/Alaska Native | Asian | Caucasian/White | Native Hawaiian/Pacific Islander | Other

Ethnicity (circle one) Hispanic | Non-Hispanic

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

Email Address | **Pharmacy Name and Cross Streets** | **Phone #**

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

INSURANCE INFORMATION

Primary Insurance | **Policy Holder** | **Relationship to Patient**

Secondary Insurance | **Policy Holder** | **Relationship to Patient**

I authorize payment directly to Weigh to Wellness Denver and authorize the release of medical information necessary to process insurance claims. I voluntarily consent to treatment for myself and/or dependents. Except under certain contractual arrangements; Medicare or Medicaid, I will be responsible for the full amount of the charges at the time of service.

Signature of Patient/Responsible Person: _____ **Date:** _____

925 S Niagara St #140
Denver, CO 80224

Phone: 303-321-2383
Fax: 303-223.-3288

Child Health History Form Date: _____

Patient Name:_____ _____
Birth date: _____ Age: _____
Mother/Guardian Name: _____
Father/Guardian Name: _____

Primary Care Provider: _____
Referring Provider: _____
ALLERGIES: _____

History of Present Condition:

Please describe your child's weight or nutrition problem. When did it begin?

_____
_____
_____

Child's weight at birth? _____
Full term pregnancy? _____ If premature, how many weeks premature? _____
Child breast fed? _____ If yes, number of months?_____

Current Dietary Habits

Typical Meal	Breakfast	Lunch	Dinner	Snacks/Desserts
Foods types and how much?		School lunch or lunch from home?		Mid morning? Mid afternoon? Evening snack? Dessert?
Time?				
Place?				

How many times per week is your family going out to eat?_____
How often does your child eat Fast Food per week? (ie: McDonald's, Taco Bell)?_____
What might they eat? _____
How many cups a day does your child drink of soda _____, juice_____, milk_____, water_____?
Who plans meals? _____ Shops?_____ Cooks?_____
Is your child a picky eater? _____. #vegetable servings daily? _____ #fruit servings daily?_____
Does the family eat whole grain bread, cereals, and pasta?_____

Current Physical Activity

Activity?			
Time spent?			
Frequency?			

What types of physical activities does your child really enjoy? _____
When does exercise fit into the child and family's schedule work best? _____
What resources do you have available to help your child be more active? Recreation Center, pool, league sports, etc..._____

Social History

Parents marital status? _____.
How many children or other persons are living with you? _____
What is the child's living situation?_____
What school does your child attend? _____
What grade is your child in?_____
Activity level at school? _____. PE time? _____. Recess time? _____

How many hours of screen time does your child have daily? (includes: TV, computer, video games)_____
Teens: Do you know of any ETOH, recreational drugs, substance abuse, cigarette smoking your teen may be using?_____

What was your family culture like with regards to food?
Does your family sit and eat together? _____ How many nights per week? _____
Do you require your child to "clean their plate"? _____
Does your child eat while watching television? _____
Do you give food as a reward for good behavior or achievements? _____
Does your child use food now to relieve stress or for "comfort"? _____

Past Medical History (Please circle all that apply)

Diabetes (or high blood sugar)	High Blood Pressure	Abnormal Cholesterol
Liver Disease	Eating Disorder	Heart Disease
Sleep Apnea	PCOS	Depression
ADHD	Anxiety	Behavioral Problems

Developments Problems (How old when they started?) _____

Other Medical problems: _____
_____

Girls: Early or delayed puberty? _____Is your daughter having periods now and at what age did they start? _____
If yes: Are periods regular and monthly or irregular? _____

Past Surgical History

Surgery Type	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications/Supplements

Please include all prescription medications, vitamins and supplements and over the counter drugs.

Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Family History

Do you have any immediate family members (parents, grandparents, siblings) who have or have had any of the following conditions?

	Yes/No	**Who?**	**Type/Notes?**
Cancer			
Diabetes/ Insulin Resistance			
Heart Disease /Heart Attack			
High Cholesterol/ Hyperlipidemia			
High Blood Pressure/ Hypertension			
Overweight			
Other Significant Medical Problems			