



## PARENT QUESTIONNAIRE

Date: \_\_\_\_\_

### PATIENT INFORMATION

NAME OF PERSON FILLING OUT THIS FORM: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current height: \_\_\_\_\_ in. Current weight: \_\_\_\_\_ lbs.

If child is a girl, has she menstruated yet? \_\_\_ no \_\_\_ yes

If yes, at what age did she first start her period? \_\_\_\_\_

### HOME LIFE

Names of:

Mother \_\_\_\_\_

Father \_\_\_\_\_

Step-mother \_\_\_\_\_

Step-father \_\_\_\_\_

Parents are:

\_\_\_ married

\_\_\_ divorced

\_\_\_ separated

\_\_\_ parents were never married \_\_\_ one parent has died \_\_\_ both parents have died

Does child live in more than one home? \_\_\_ no \_\_\_ yes

If yes, primary custody \_\_\_ mother \_\_\_ father \_\_\_ shared

Ages and names of sisters or step-sisters: \_\_\_\_\_

\_\_\_\_\_

Ages and names of brothers or step-brothers: \_\_\_\_\_

\_\_\_\_\_

Job status	Job Title	Full Time	Part time
Mother	_____	_____	_____
Father	_____	_____	_____
Step-father	_____	_____	_____
Step-mother	_____	_____	_____

Education                      Highest level completed  
 Mother \_\_\_\_\_  
 Father \_\_\_\_\_

RECENT CHANGES OR STRESSORS

\_\_\_\_ Move to new home      \_\_\_\_ Parent loss of a job      \_\_\_\_ Change in living situation  
 \_\_\_\_ Death in family      \_\_\_\_ Move to new school      \_\_\_\_ Parent separation or divorce  
 \_\_\_\_ Major illness in family member      \_\_\_\_ Death of a friend      Other: \_\_\_\_\_

Does anyone smoke at home, either inside or outside?      \_\_\_\_ yes      \_\_\_\_ no  
 Are there any pets at home?      \_\_\_\_ yes      \_\_\_\_ no

CONCERNS ABOUT WEIGHT:

Do you feel your child weighs more than other children the same age?      \_\_\_\_ yes      \_\_\_\_ no

If yes, when did you first notice this difference? At \_\_\_\_ years old

How concerned are you about your child's weight? (Circle the best answer)

1) Not at all      2) A little      3) Pretty much      4) Very much

Please rate the following types of concerns about your child's weight.

	Not all	A little	Pretty much	Very much
Health issues at present	1	2	3	4
Health issues in the future	1	2	3	4
Teasing	1	2	3	4
Low self esteem	1	2	3	4
Depression	1	2	3	4
Interference with physical				
Activity	1	2	3	4
Clothes don't fit	1	2	3	4

Have any of the following people expressed concern about your child's weight? (Check all that apply)

\_\_\_\_ Doctor      \_\_\_\_ Child's other parent      \_\_\_\_ Child's sibling(s)      \_\_\_\_ Grandparent(s)  
 \_\_\_\_ Coach      \_\_\_\_ Teacher      \_\_\_\_ Friend  
 \_\_\_\_ No one else has expressed concern about my child's weight.

Does your child's growth pattern so far remind you of the childhood growth pattern of anyone else in the family?      \_\_\_\_ yes      \_\_\_\_ no      If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

In your opinion, what factors may be causing your child to be overweight? (Check all that apply)

	Yes	No	Not sure
Eating too much	_____	_____	_____
Eating the wrong kinds of food	_____	_____	_____
Not enough exercise	_____	_____	_____
Too much TV	_____	_____	_____
Too many video games	_____	_____	_____
Too much time on the computer or internet	_____	_____	_____
Genetics (it runs in the family)	_____	_____	_____
Gland or hormone problem	_____	_____	_____
Medication-related	_____	_____	_____
Other medical problem(s)	_____	_____	_____
Life stressor	_____	_____	_____
Emotional stress (i.e. depression or boredom)	_____	_____	_____

List all commercial diet programs your child has tried (i.e. Weight Watchers, Jenny Craig, etc.) \_\_\_\_\_

Were they helpful or not? \_\_\_\_\_

List all popular diets your child has tried (i.e. Atkins, South Beach, etc.) \_\_\_\_\_

Were they helpful or not? \_\_\_\_\_

Has your child ever consulted a dietician before? \_\_\_\_ yes \_\_\_\_ no

If yes, was it helpful? \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ somewhat

How concerned do you feel your child is about his/her weight?

\_\_\_\_ Very concerned                      \_\_\_\_ Somewhat concerned                      \_\_\_\_ A little concerned

\_\_\_\_ Not at all concerned                      \_\_\_\_ I don't know

Has your child tried any weight loss medications or supplements? \_\_\_\_ yes \_\_\_\_ no

If yes, please list: \_\_\_\_\_

If yes, was it/were they helpful or not? \_\_\_\_\_

What methods is your child currently using to try to lose weight?

- |                             |                             |  |
|-----------------------------|-----------------------------|--|
| ____ eat less               | ____ decrease portion size  | ____ eat more of a certain food            |
| ____ cut out meals          | ____ cut out a certain food | ____ diet plan                             |
| ____ exercise more          | ____ go to a gym            | ____ weight control program                |
| ____ weight loss supplement |                             | ____ my child is not trying to lose weight |

To what extent have you discussed your child's weight with him/her?

A lot     Somewhat     A little     Not at all

How would you characterize your child's response to these discussions?

N/A     Guarded/Defensive     Open to discussion  
 Somewhere inbetween

How confident are you that your child can make changes towards a healthier lifestyle?

(Circle the best answer)

0      1      2      3      4      5      6      7      8      9      10

Not confident

Somewhat confident

Very confident

Is anyone else in the family trying to lose weight?     yes     no

<input type="checkbox"/> Biological mother	How: _____
<input type="checkbox"/> Biological father	How: _____
<input type="checkbox"/> Stepmother	How: _____
<input type="checkbox"/> Stepfather	How: _____
<input type="checkbox"/> Sibling	How: _____
<input type="checkbox"/> Grandparent	How: _____

### PAST MEDICAL HISTORY

Any maternal problems during or right after pregnancy (check all that apply):

none     diabetes     vomiting     high blood pressure  
 too little weight gain     too much weight gain     post-partum depression  
 other (specify: \_\_\_\_\_)

Birth weight (pounds or kg): \_\_\_\_\_

Birth history:  early     late     on time

Breast fed until what age? (months) \_\_\_\_\_

Were there any medical problems as a newborn?

none     infection     jaundice     breathing problems  
 floppy muscles     poor growth

Were there any feeding problems in the first year of life?     yes     no

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any feeding problems after one year of age?    \_\_\_ yes    \_\_\_ no

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have there been any developmental delays with your child?    \_\_\_ yes    \_\_\_ no

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are your child's immunizations up to date?    \_\_\_ yes    \_\_\_ no    \_\_\_ not sure

**HOSPITALIZATIONS** (staying overnight in the hospital)

\_\_\_ None    \_\_\_ Yes (If yes, please include the following information)

Age	Month/Year	Reason	Name of Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SURGERIES**

\_\_\_ None    \_\_\_ Yes (If yes, please include the following information)

Age	Month/Year	Reason	Name of Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL PROBLEMS:** Please list. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PSYCHIATRIC OR DEVELOPMENTAL PROBLEMS:** Please list. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS (please include herbs, vitamins and supplements): \_\_\_\_\_

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ALLERGIES:

\_\_\_\_ Medications: List: \_\_\_\_\_

\_\_\_\_ Foods: List: \_\_\_\_\_

\_\_\_\_ Stinging insects      \_\_\_\_ Asthma      \_\_\_\_ Other: Specify \_\_\_\_\_

REVIEW OF SYSTEMS:

Does your child currently have any of the following problems or has he/she had any of these problems in the last six months? Check all that apply.

	Yes	No	Not sure
Blurry vision	_____	_____	_____
Headaches	_____	_____	_____
Nasal congestion/Allergies	_____	_____	_____
Snoring	_____	_____	_____
Sleep apnea (pauses in breathing during sleep)	_____	_____	_____
Excessive daytime sleepiness	_____	_____	_____
Dental caries/cavities	_____	_____	_____
Acne	_____	_____	_____
Eczema (skin allergy)	_____	_____	_____
Excessive hair growth on skin	_____	_____	_____
Darkening of the skin on the neck, under the arms, or around the waist	_____	_____	_____
Stretch marks	_____	_____	_____
Breast enlargement (apart from normal development)	_____	_____	_____
Irregular menstrual periods	_____	_____	_____
Paleness	_____	_____	_____
Chest pain	_____	_____	_____
Shortness of breath with exercise	_____	_____	_____
Stomach aches	_____	_____	_____
Vomiting	_____	_____	_____
Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
Reflux	_____	_____	_____

	Yes	No	Not sure
Urinary tract infections			
Bedwetting	_____	_____	_____
Nocturia (waking up at night to use the bathroom)	_____	_____	_____
Daytime leakage of urine	_____	_____	_____
Extra urination	_____	_____	_____
Extra thirst	_____	_____	_____
Recent unintended weight loss	_____	_____	_____
Back pain	_____	_____	_____
Hip pain	_____	_____	_____
Knee pain	_____	_____	_____
Behavior problem	_____	_____	_____

### FAMILY HISTORY

	D.O.B.	Height	Weight
Biological mother	_____	_____	_____
Biological father	_____	_____	_____

Please check all the biological relatives of your child on either side of the family that currently have or have had these conditions in the past. If none, leave blank. MO = Mother, FA = Father, GM = Grandmother, GF = Grandfather, Other = Other relative

	MOTHER'S SIDE				FATHER'S SIDE				SIBLING
	MO	GM	GF	Other	FA	GM	GF	Other	
Overweight	_____	_____	_____	_____	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____	_____
Heart attack	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Thyroid problem	_____	_____	_____	_____	_____	_____	_____	_____	_____
Gallbladder problem	_____	_____	_____	_____	_____	_____	_____	_____	_____
Polycystic ovaries	_____	_____	_____	_____	_____	_____	_____	_____	_____
Eating disorder	_____	_____	_____	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____	_____	_____	_____
Learning Disabilities	_____	_____	_____	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____	_____	_____	_____
ADD/ADHD	_____	_____	_____	_____	_____	_____	_____	_____	_____
Substance Abuse	_____	_____	_____	_____	_____	_____	_____	_____	_____
Weight loss Surgery	_____	_____	_____	_____	_____	_____	_____	_____	_____

Are there any other medical problems that run in the family? \_\_\_\_\_

Are there any other psychiatric problems that run in the family? \_\_\_\_\_

### EATING HABITS

Who does most of the food shopping for the family?

\_\_\_ Mother \_\_\_ Father \_\_\_ Other (Who? \_\_\_\_\_)

Who cooks most of the meals in the family?

\_\_\_ Mother \_\_\_ Father \_\_\_ Other (Who? \_\_\_\_\_)

About how often does your child eat out at restaurants of any kind?

\_\_\_ once or more a day      \_\_\_ once a week      \_\_\_ several times per week  
\_\_\_ about once a month      \_\_\_ less than once a month

What restaurants does your child go to most often, including fast food restaurants? \_\_\_\_\_

Does your child independently buy snacks from a supermarket, convenience store, school, or fast food outlet near your home? \_\_\_ no \_\_\_ yes

Does your child drink soda? \_\_\_ no \_\_\_ yes

If yes, how much? \_\_\_\_\_ Diet or regular? \_\_\_\_\_

Does your child drink juice? \_\_\_ no \_\_\_ yes

If yes, how much? \_\_\_\_\_

Does your child drink milk? \_\_\_ no \_\_\_ yes.

If yes, how much per day? \_\_\_\_\_

What type? \_\_\_ nonfat \_\_\_ 1% \_\_\_ 2% \_\_\_ whole

	Not at all	A little	Pretty much	A lot	Very much
Does your child like fruit?	1	2	3	4	5
Does your child like vegetables?	1	2	3	4	5

HOW STRONGLY DO YOU AGREE WITH THE FOLLOWING STATEMENTS ABOUT MEALTIMES IN YOUR FAMILY?

a) In our family, it is important that the family eat at least one meal a day together.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

b) In our family, mealtime is a time for talking with other family members.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

c) In our family, it is often difficult to find a time when family members can sit down to a meal together.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

d) In our family, we often watch TV while eating dinner.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

e) Mealtime in our family is generally pleasant and enjoyable.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

f) Manners are important at our dinner table.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

g) In our family, a child should eat all the foods served even if he/she doesn't like them.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

h) In our family, we usually eat meals at the kitchen/dining room table.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

i) In our family, it is ok for a child to make something else to eat if he/she doesn't like the food being served.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

j) In our family, the overriding tendency is to serve structured meals and snacks.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

k) In our family, the overriding tendency is to allow grazing (eating when the whim strikes).

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

l) I am a good role model for my child in terms of my eating.

\_\_\_ Strongly disagree \_\_\_ Somewhat disagree \_\_\_ Somewhat agree \_\_\_ Strongly agree

m) My spouse/partner is a good role model for my child in terms of eating.

Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

n) Weight and dieting (as they pertain to anyone) are frequent topics of conversation in my home.

Strongly disagree  Somewhat disagree  Somewhat agree  Strongly agree

WHAT KIND OF SPORTS DOES YOUR CHILD PARTICIPATE IN?

In a usual week, how many hours does your child spend doing the following activities:

Strenuous exercise (heart beats rapidly). Examples: biking fast, aerobic dancing, running, jogging, swimming laps, rollerblading, skating, lacrosse, tennis, cross country skiing, soccer, basketball, football

none  less than 1/2 hr a week  1/2-2 hrs a week  
 2 1/2 - 4 hrs a week  4 1/2 - 6 hrs a week  6+hrs a week

Moderate exercise (not exhausting). Examples: walking quickly, baseball, gymnastics, easy bicycling, volleyball, skiing, dancing, skateboarding, snowboarding.

none  less than 1/2 hr a week  1/2-2 hrs a week  
 2 1/2 - 4 hrs a week  4 1/2 - 6 hrs a week  6+hrs a week

Mild exercise (little effort). Examples: Walking slowly (to school, to friend's house, etc.), bowling, golf, fishing, yoga

none  less than 1/2 hr a week  1/2-2 hrs a week  
 2 1/2 - 4 hrs a week  4 1/2 - 6 hrs a week  6+hrs a week

Is your child in a sport or activity where it's important to stay a certain weight (i.e. wrestling, gymnastics, ballet, etc.)?  yes  no

During the past 12 months, on how many sports teams did he/she play ?

0 teams  1 team  2 teams  3 or more teams

In his/her free time on an average weekday (Monday-Friday), how many hours does your child spend

	0 hr	1/2 hr	1 hr	2 hr	3 hr	4 hr	5+hr
Watching TV/playstation/Wii, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading and doing homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a computer or other electronic devices, not for homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On an average weekend day (Saturday or Sunday), how many hours does your child spend

	0 hr	½ hr	1 hr	2 hr	3 hr	4 hr	5+hr
Watching TV/play station/Wii, etc.	___	___	___	___	___	___	___
Reading and doing homework	___	___	___	___	___	___	___
Using a computer or other electronic devices, not for homework	___	___	___	___	___	___	___
Is there a television in your child's room ?	___ yes	___ no					

How often does he/she watch television while eating meals ?  
\_\_\_ always \_\_\_ usually \_\_\_ sometimes \_\_\_ rarely \_\_\_ never

How often does he/she snack while watching TV ?  
\_\_\_ always \_\_\_ usually \_\_\_ sometimes \_\_\_ rarely \_\_\_ never

HELP US TO KNOW YOUR CHILD

What about him/her makes you proud? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What seems to be the greatest challenge for him/her? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May we share your answers with your child? \_\_\_ yes \_\_\_ no

**THANK YOU FOR YOUR PATIENCE AND HONESTY IN ANSWERING THESE QUESTIONS!!**

Is there anything else you would like us to know about you, your child or your family?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_