FOR CLINIC USE ONLY

VITALS

BP: _____ HR: _____ R: _____ T: _____ SpO2: _____

PAIN: Y / N Scale: _____ / 5

WEIGHT (kg): _____ LENGTH/HEIGHT (cm): _____ BMI (kg/m2): _____

BMI Z-score: _____, or _____% of the 95th percentile (use PediTools.org)

LEARNING ASSESSMENT

1.	What is your preferred language?
2.	What is your preferred method of learning?
	□ Verbal □ Written □ Other (specify)
3.	Do you have a specific barrier to learning? (For example, a learning disability, hearing or visual impairment, or other barrier) If yes, please explain in the comments box.
	□ Yes □ No
4.	Do you have any cultural or religious beliefs that may impact the medical care you receive? If yes, please explain in the comments box.
	□ Yes □ No

Medical History

Please complete the following for the person being seen today.
If this is your initial visit, please complete in entirety and circle all that apply.
For follow-up visits, you can just note any updates.

<table>
<tr>
<td>Birth and Developmental History
o Prematurity (<37 weeks)
o Nursery complications
o Other:</td>
<td>Current Medications, Vitamins, and Supplements (prescribed and over-the-counter)
o Multivitamin
o Other:</td>
</tr>
<tr>
<td>Diagnosed conditions
o Pre-diabetes or diabetes
o High blood pressure
o High cholesterol
o Sleep apnea
o Anxiety or depression
o Other:</td>
<td>History of other medications
o Depo-Provera
o Mood-regulating medications (for anxiety, depression, etc.)
o Oral or inhaled steroids
o Other:</td>
</tr>
<tr>
<td>Surgeries or Overnight Hospitalizations</td>
<td>Allergies to medications or food</td>
</tr>
<tr>
<td>Serious trauma (fractures, head injuries, vehicle accident, etc.)</td>
<td>Immunizations
Up-to-date for age Y / N
Seasonal flu Y / N
COVID-19 series Y / N</td>
</tr>
<tr>
<td colspan="2">Family history (please indicate relationship to the patient, e.g. parent, grandparent, siblings)
o Diabetes:
o Thyroid disease:
o High blood pressure:
o High cholesterol:
o Early heart attack or stroke (under 60):
o Liver disease:
o Polycystic ovary syndrome:
o Concerns about weight:
o Other:</td>
</tr>
</table>

What specific concerns would you like to discuss today?

If applicable, at what age did weight or BMI become concerning?

If applicable, what interventions have been tried?

Have you made any changes since you were referred to this clinic?

What do you hope to achieve from this clinic?

Current Habits *Please complete based on typical habits, or what is done most of the time.*

Sleep

Bedtime _____ am/pm, Fall asleep_____ am/pm, Wake for the day_____ am/pm

Nutrition

Typical number of meals/day: _____. Examples:

Typical number of snacks/day: _____. Examples:

How many times/week do you get food from a restaurant (fast-food, coffee shop, dining in, etc.)? _____

Examples:

Typical beverages consumed during the day:

Screen time

Estimated screen use for entertainment (phone, tablet, laptop, video games, etc.): _____ hours/day

Estimated screen use for other purposes such as school or work: _____ hours/day

Physical activity

School PE: _____ Days/week. Is this in-person or virtual?

Other activities: _____ Days/week and _____ minutes/day. Examples:

Favorite physical activities:

Review of Symptoms

Please mark any of the following symptoms that the patient has been experiencing within the past 3 months:

Unexplained lack of energy	Headaches	Limb swelling	Abdominal pain	Increased thirst	Joint pain
Excessive sleepiness	Vision changes	Temperature intolerance	Nausea	Increased daytime urination	Exercise limitations
Snoring	Chest pain	Unexplained skin darkening	Vomiting	Waking at night due to urination	Concerns about mood
Gasping for air at night	Heart palpitations	Severe acne	Diarrhea	Wetting accidents day or night	Unexplained weight changes
Apnea (pauses in breathing)	Difficulty breathing	Unexpected hair growth	Constipation	Irregular periods	Concerns about appetite or overeating

Please give a brief explanation for any symptoms circled above:

Are there any other symptoms that you'd like to discuss?

Preferred phone number: _____ Relationship to patient: _____

Is it okay to leave voicemail? Y / N

Alternate phone number: _____ Relationship to patient: _____

Is it okay to leave voicemail? Y / N

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritated				
7. Feeling afraid as if something awful might happen				
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

Generalized Anxiety Disorder Screener (GAD-7)

Scoring and Interpretation:

GAD-2 Score*	**Provisional Diagnosis**
0-2	None
3-6	Probable anxiety disorder
GAD-7 Score	**Provisional Diagnosis**
0-7	None
8+	Probable anxiety disorder

*GAD-2 is the first 2 questions of the GAD-7

References:

- Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine. May 22 2006;166(10):1092-1097. PMID: 16717171
- Kroenke K, Spitzer RL, Williams JB, Monahan PO, Lowe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Annals of internal medicine. Mar 6 2007;146(5):317-325. PMID: 17339617
- Lowe B, Decker O, Muller S, et al. Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. Medical care. Mar 2008;46(3):266-274. PMID: 18388841

PHQ-9 modified for Adolescents (PHQ-A)

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Modified SCOFF Questionnaire

This is a brief questionnaire that is looking at your inner attitudes and feelings about food. Please read the questions below and check Yes or No as appropriate.

1) Do you ever make yourself throw up (or use laxatives, water pills or exercise) because you feel uncomfortably full?

   ☐ **Yes** ☐ **No**

2) Do you worry you have lost control over how much you eat?

   ☐ **Yes** ☐ **No**

3) Have you recently lost or gained more than 10-15 pounds in a 3 month period?

   ☐ **Yes** ☐ **No**

4) Do thoughts and fears about food and weight dominate your life?

   ☐ **Yes** ☐ **No**

5) Do you feel bad about yourself because of your weight, shape, or eating habits?

   ☐ **Yes** ☐ **No**

Score: _____

Adopted from: SJMHS-Ann Arbor, Huron Oaks Adult Partial Hospitalization Program

Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ 1999; 319:1467.
Modified SCOFF developed by Dooley-Hash, S. and Banker, JD, 2011, Center for Eating Disorders, center4ed.org

Adverse Childhood Experiences (ACEs) Questionnaire

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down, or humiliate you? or
   Act in a way that made you afraid that you might be physically hurt?
   ◯ Yes ◯ No

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   ◯ Yes ◯ No

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way? or
   Attempt or actually have oral or anal intercourse with you?
   ◯ Yes ◯ No

4. Did you often or very often feel that …
   No one in your family loved you or thought you were important or special? or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ◯ Yes ◯ No

5. Did you often or very often feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ◯ Yes ◯ No

6. Was a biological parent ever lost to you through divorced, abandonment, or other reason?
   ◯ Yes ◯ No

7. Was an adult in your household:
   Often or very often pushed, grabbed, slapped, or had something thrown at them? or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ◯ Yes ◯ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ◯ Yes ◯ No

9. Was a household member depressed or mentally ill? or
   Did a household member attempt suicide?
   ◯ Yes ◯ No

10. Did a household member go to prison?
    ◯ Yes ◯ No

Social and Military Family History
Please complete the following for the person being seen today.

How would you describe your race and/or ethnicity?

How would you describe your gender?

Who all lives in your household?

How many times has your family moved to a different state or country?

How many different schools have you attended?

Which of your parents (biological, step-, adoptive, etc.) has served or is serving in the military?

These questions are about the military service history of the parent/guardian(s). Please complete with their assistance.

Servicemember #1: _____ Relationship to patient:
How many years did you serve?
What branch?
What was your job in the military?
What is/was the highest rank achieved?
How many times were you deployed (that the patient has experienced)?
Were you ever deployed or temporarily assigned to a hostile or combative area? Y / N
Were you wounded, injured, or hospitalized related to a deployment? Y / N

Servicemember #2: _____ Relationship to patient:
How many years did you serve?
What branch?
What was your job in the military?
What is/was the highest rank achieved?
How many times were you deployed (that the patient has experienced)?
Were you ever deployed or temporarily assigned to a hostile or combative area? Y / N
Were you wounded, injured, or hospitalized related to a deployment? Y / N

Servicemember #3: _____ Relationship to patient:
How many years did you serve?
What branch?
What was your job in the military?
What is/was the highest rank achieved?
How many times were you deployed (that the patient has experienced)?
Were you ever deployed or temporarily assigned to a hostile or combative area? Y / N
Were you wounded, injured, or hospitalized related to a deployment? Y / N