Welcome to the Allina Health Kids, Teens & Young Adults Weight Management Program!

This program is available to help you achieve a healthier weight. Your health care team will help you with your concerns about weight and how it might be affecting your health.

Each team member specializes in caring for kids, teens and young adults who have obesity. For additional support in talking as a family about weight and health: www.weighinonobesity.org

Meet Your Health Care Team

Doctor

The doctor will complete a medical evaluation and create an individual treatment plan. The treatment plan will may include lab tests, medication recommendations, and referrals to other specialists.

Dietitian

The dietitian will look at current eating habits and overall nutrition to help you set small goals to make improvements in food choices, portion sizes, and mindful eating strategies.

Clinical Psychologist

The psychologist will help you with thoughts, moods, habits and stress that might get in the way of sticking to your goals. She will help you find ways to make hard things easier.

During your care, the psychologist may provide ongoing therapy or connect you with someone closer to school or home.

Nurse

The nurse will be a good contact person during your care. She can answer questions about your care, treatment, recommendations, progress and any others you might have.

Social Worker

The social worker will help you and your family find resources in your community to help carry out recommendations and referrals.

Courage Kenny Kids Physical Therapists

The physical therapists evaluate your current physical abilities and fitness routines. She will work with you and your family to set physical activity goals that are right for you and may help find a physical therapist closer to your home for continued care.

Surgeon

For some kids, teens, and young adults, working with the specialists in our program may include discussions about weight loss surgery. If you and the team decide that weight loss surgery is right for you or you have questions about this weight loss option, you can sit down with Dr. Linden to learn more and get any questions answered.

PRINT SAVE AS EMAIL RESET

INSURANCE VERIFICATION FORM
Kids, Teens & Young Adults 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: _____

Emergency Contact: _____ Phone Number: _____

Parent / Legal Guardian: _____

Person Completing Form: _____ Relationship to Patient: _____

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

	Yes	No
Has the patient tried any diet programs in the past? If yes, which one(s)?	☐	☐
Has the patient tried medications to lose weight? If yes, which one(s)?	☐	☐
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?		Does the patient snack after dinner? ☐ Yes ☐ No
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?	

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:

	Food Allergies	Sensitivities	Intolerances	Food Cravings	Food Dislikes
Please list:					

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/Sports drinks/ Energy drinks					
Regular soda/Sports drinks/ Energy drinks					
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:

Medical History

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

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

Mental Health

Has the patient ever been diagnosed with:

	Yes	No	Date of diagnosis	Treatment
Autism				
ADHD				
Depression				
Bipolar				
Anxiety / Panic attacks				
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)	☐	☐		
other heart tests?	☐	☐		
sleep study (or screening for sleep apnea)	☐	☐		Treatment?
upper endoscopy procedure(s) (EGD)?	☐	☐		
colonoscopy?	☐	☐		

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?	☐	☐	

Surgical History

Surgery	Year	Incision location	Reason

	Yes	No	Comment
Has the patient had problems with anesthesia?			

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?		

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:

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: ☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ Other: _____
(check one)

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? _____