

Welcome to OrthoHealth

An Investment in You, Your Health & A Happier Healthier Lifestyle

CONGRATULATIONS. You have made the decision to invest in your child's health by joining IBJI's healthy lifestyles program. We are excited that you have put your trust in us to be a part of the journey toward better health and wellness.

As your OrthoHealth care team we are committed to knowing your family and child in order to create a treatment plan that makes sense and leads to achievable goals for optimal health.

To prepare you and your child for your first visit we have included detailed health questionnaires to help your physician get a full picture of your child's health, lifestyle and goals for the program. Please take the time to fill these out to the best of your ability and send back to us before your first appointment so that your physician has time to review prior to your visit. At which time your physician will discuss in more detail and develop a treatment plan, that may include changes in eating , sleeping and movement. Your first appointment will include meeting with the nutritionist and the health coordinator . Please be prepared to spend 90 minutes at your first appointment . *Subsequent appointments will ideally be scheduled weekly, for the first 3-5 weeks with either the Nutritionist or Physician and may take up to 45 minutes, with the option of meeting virtually. There will also be bi-weekly phone check-ins that will take 15 minutes which will allow you the opportunity to ask any questions that might arise between appointments. Visits will be tapered down based on need. Our goal is to ensure you feel supported on your journey to a healthier you.*

Meet your care team:

Dr. Lynn Gettleman Chehab, Your Medical Provider, creating an in depth treatment plan that starts with getting to know your child or teen and family dynamic. She is committed to helping you each step of the way in making important long term lifestyle changes when you are ready.

Your Health Coordinator is here to help you put the plan into action by addressing lifestyle changes that will be necessary to attain your optimum health. The bi-weekly check-ins will be with your coordinator to discuss success and challenges that have come up as you make lifestyle changes. We will also be able to help coordinate any outside referrals and make sure you have the necessary tools and resources to set you up for success.

Your Registered Dietician will guide you through proper nutrition for your body and educate you on proper hydration and nutrition to optimize your energy and metabolic health. Food is your best medicine so learning what your body needs to eat to keep you healthy is a primary goal.

****You may fill out your paperwork online and email it back to us at Orthohealth@IBJI.com OR print it out and bring with you to your first appointment.**

_____(Pt initials)

IBJI OrthoHealth– Pediatric Intake

To be filled out by PATIENT (Parents, see separate form)

Please take a few minutes to answer the following. These items will be discussed in more depth with your OrthoHealth provider.

Patient Name

Date of Birth

MRN
(office use only)

Program Information

What do you hope to learn, achieve or gain from the OrthoHealth program?

DIET: Please think of what you ate in the past 24 hours

Meal	Time	Foods	Drinks	Notes
Breakfast				
Morning snacks				
Lunch				
Afternoon snacks				
Dinner				
Evening snacks				

What time of day do you normally start eating? _____

What time of day do your normally stop eating? _____

Do you normally eat breakfast on school days? Yes No

Do you normally eat lunch on school days? Yes No

When school is in session, do you bring lunch from home or eat school-made lunch? And what do you usually eat?

How many nights a week do you eat dinner with a parent? _____

Do you feel full after meals? Yes No

Do you ever wake up to eats in the middle of the night? Yes No

Do you want to eat more when you are stressed? Yes No

What time of day do you feel most hungry? _____

How many meals do you eat out or take out per week? (include breakfast, lunch and dinner) _____

Who does the grocery shopping? _____ Who does the cooking? _____

Do **you** enjoy cooking? Yes No

What are your favorite foods?

What are some of the foods you will not eat?

What types of foods do you crave?

Stress

How would you describe yourself? (Select One Option)

- I am calm and easy going I am sometimes calm but frequently impatient
- I am hard driving and can never relax
- I am seldom calm

Please select your stress level:

(0= No Stress, 5= Moderate Stress, 10= Extreme Stress)

- 0 1 2 3 4 5 6 7 8 9 10

Please describe major sources of stress in your life and how they affect you:

What helps you relieve your stress?

Sleep Habits

What time do you get into bed? _____ What time do you turn off the lights? _____

What do you do in bed before going to sleep? _____

Is your cell phone in the room with you? Yes No Do you use your phone as an alarm clock Yes No

What time do you usually wake up? _____ Do you wake up during the night? _____

Do you snore? Yes No I don't know

Do any of these describe you?

I wake up in the morning still tired Yes No

I have to take naps during the day Yes No

I have to sleep with >1 pillow Yes No

Have you ever had a sleep study? Yes No

I wake up feeling well rested Yes No

I wake up with a dry mouth and sore throat Yes No

On a scale of 0-10, how would you rate the quality of your sleep?
(0-poor sleep, 5-moderate or ok sleep, 10 best sleep)

0 1 2 3 4 5 6 7 8 9 10

What concerns you most about your sleep, if anything?

Activity / Exercise

How often do you exercise and for how long?

What activity or exercises do you enjoy?

What physical activity or exercise have you done in the past 30 days?

____(pt initials)

OrthoHealth – (parents: please fill this out as it applies to your child)

Patient Name

Date of Birth

MRN
(office use only)

Referring Doctor to OrthoHealth: _____

Current Prescription Medication & Over the Counter Herbs/Supplements

Medication/Herbs/Supplement	Dosing	Purpose	Year Started

Allergies

Is the patient allergic to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy:	Reaction:
Allergy:	Reaction:
Please list additional allergies to food, supplements, environmental, other:	

Prior Surgeries

Date:	Surgery:
Date:	Surgery:

Prior Hospitalizations

Date:	Reason:
Date:	Reason:

Your Child's Medical History (Please select all that apply.)

(Please check any of the following your child is currently experiencing)

- Endocrine:**
 - Fatigue
 - Excessive thirst
 - Acne
 - Always Cold
 - Irregular Menses/No Menses
 - Excessive facial hair
 - Always Hot

- Cardiovascular:**
 - Palpitations
 - Irregular Heartbeat
 - Chest pain

- Pulmonary/
Breathing:**
 - Coughing
 - Shortness of breath while walking, climbing stairs or exercising
 - Wheezing
 - Snoring

- Gastrointestinal:**
 - Reflux/heartburn
 - Nausea
 - Abdominal pain
 - Diarrhea
 - Constipation

- Neurological/
Psychiatric:**
 - Headaches
 - Depression
 - Insomnia
 - Anorexia
 - Numbness/Tingling
 - Anxiety
 - School Avoidance
 - Bulimia
 - Tremors
 - ADHD
 - Bullying
 - Binge Eating Disorder

Other: _____

Personal & Family Medical History (Please check all that apply to the patient & family)

	Patient	Mother	Father	Grandparent	Sibling	Aunt/Uncle
Excess Weight						
High Cholesterol						
Diabetes						
Heart Disease						
Heart Attack or Stent						
Stroke/TIA						
Sudden Death before 50						
High Blood Pressure						
Pulmonary Embolism or Other Clotting Disorder						
Arthritis						
Fibromyalgia						
Lupus						
Ulcerative Colitis/Crohn's Disease						
Thyroid Disease						
Osteopenia/Osteoporosis						
Anxiety						
Depression						
Asthma / Emphysema or COPD						
Gall Bladder Disease						
Gout						
Cancer						
What Type: _____						

Date Of Last Physical Exam with PCP: _____ Date of Last Completed Labs: _____

Are any immediate family members deceased? If yes, please list year and cause of death: Yes No

Your child's weight history:

Patient's birthweight and gestational age: _____ Gestational diabetes with pregnancy? Yes No

Was your child breast fed and for how long? _____

At what age did you become concerned about his/her/their weight? _____

Is your child concerned about his/her/their weight? Yes No

Do you think that there is a reason or an inciting event? _____

Has your child ever participated in a weight management program and if yes, what kind of program (doctor's office, Weight Watchers, etc) and was it successful? Yes No

Are you concerned that your child is teased or bullied about his/her/their weight? Yes No

Social History

Parental marital status: _____

Who does your child live with (please list if there are multiple households): _____

Child's grade and school: _____

Is your child currently in-school, remote, or in hybrid learning? _____

Does your child have a history of learning disabilities or school avoidance? _____

Does your child have one friend or group of friends that "have their back"? _____

Sleep History

What time does your child go to bed on a weeknight? _____ Wake time? _____

What time does your child go to bed on a weekend night? _____ Wake time? _____

Does your child snore? Yes No Not Sure

Does your child sleep with his/her/their phone in the bedroom? Yes No Not Sure

Does your child usually wake up more than once during the night? Yes No Not Sure

Food History

Who does the grocery shopping for each household? _____

Who usually prepares:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How many times a week does your child eat restaurant/fast/take-out food? _____

Frozen or packaged food? _____

How many dinners a week does your child eat with at least one parent? _____

Are you ever concerned about not having enough food or enough money to buy food? Yes No

Do you think that your child binges or stress eat? Yes No

Do you have specific concerns about your child's eating habits? Yes No

If Yes, please list your concerns _____

What would you like to learn from OrthoHealth?

To the best of my knowledge, the above information is accurate and complete.

Patient Signature _____ Date ____ / ____ / ____