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.

Jake Tamillo, Your Program Coordinator , He will be your initial contact person and is responsible for scheduling initial appointments and supportive services.

****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.**

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?
_____
_____

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?	☐ Yes ☐ 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 ☐ Always Cold ☐ Always Hot
☐ Excessive thirst ☐ Irregular Menses/No Menses
☐ Acne ☐ Excessive facial hair

Cardiovascular: ☐ Palpitations ☐ Irregular Heartbeat ☐ Chest pain

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

Gastrointestinal: ☐ Reflux/heartburn ☐ Abdominal pain ☐ Constipation
☐ Nausea ☐ Diarrhea

Neurological/ Psychiatric: ☐ Headaches ☐ Numbness/Tingling ☐ Tremors
☐ Depression ☐ Anxiety ☐ ADHD
☐ Insomnia ☐ School Avoidance ☐ Bullying
☐ Anorexia ☐ Bulimia ☐ 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 ___ / ___ / ___