Family Questionnaire

Date

Name of person completing questionnaire **Relationship to child**

Name of individual who initiated the referral to the PCWH

Name of child's primary care physician

Child

Name **Date of birth (mm/dd/yy)**

Street address **City** **Prov** **Postal code**

Guardians

Guardian A

Name **Date of birth (mm/dd/yy)**

Home *Work* *Cell*

Daytime contact number(s)

Email address

We only email general PCWH information, newsletters, and special event notices. We will not share your email address with others.

I am the child's: ☐ Mother ☐ Father ☐ Legal Guardian

☐ Other (Specify): _____

Pediatric Centre for Weight and Health
2nd Floor, Mother Rosalie Health Services
16930 87 Avenue Edmonton, AB T5R 4H5

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Fax 780.735.2794

Guardian B

Name _____ **Date of birth (mm/dd/yy)** _____

Home *Work* *Cell*

Daytime contact number(s) _____

Email address _____

We only email general PCWH information, newsletters, and special event notices. We will not share your email address with others.

I am the child's: ☐ Mother ☐ Father ☐ Legal Guardian

☐ Other (Specify): _____

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Other (Specify): _____

In the case of divorce or separation, is there: ☐ Shared custody ☐ Full custody*

*If selecting full legal custody, attach supporting legal documentation

List everyone who lives in the home and their relationship to the child:

Name	Age	Relationship to child	Occupation or grade	Weight concerns *(Yes/No)*

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Is your child on any medications or supplements? ☐ No ☐ Yes, list and indicate dose below

Medication / Supplement name	Dose / Amount	Reason for medication	Prescribing physician name

Are there other health professionals currently involved in your child's care? ☐ No ☐ Yes, indicate below:

i.e., endocrinologist, psychiatrist, school counsellor

Does your child have any health conditions (i.e., asthma, diabetes) **or mental health diagnoses we should know about?** ☐ No ☐ Yes, indicate below:

Are you concerned about your child's weight? ☐ No ☐ Yes, when did you first become concerned?

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Were there any significant events or life changes around that time? ☐ No ☐ Yes, describe:

i.e., death in family, birth of sibling, parents separated, trauma

Describe any specific concerns that you may have about your child:

How do you hope the PCWH can be of help to your family?

Has your child used any of the following behaviours to try to lose weight? ☐ No ☐ Yes, describe:

i.e., skipping meals, vomiting, medications, exercised too much, fad diet

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Are there challenges you foresee in making healthy lifestyle changes for your family and child? ☐ No ☐ Yes, describe

Does anyone tease your child? (i.e., at school or home) ☐ No ☐ Yes, describe

School History

Name of school _____ **Grade** _____

How are your child's grades? ☐ Poor ☐ Below Average ☐ Average ☐ Above Average ☐ Excellent

Has your child ever been diagnosed with a learning disability or developmental disorder? ☐ No ☐ Yes, explain

Is your child receiving extra help in school? ☐ No ☐ Yes, describe

Other Caregivers or Meal Providers:

Does your child spend a significant amount of time with other care providers or in other households such as a day care/home or a grandparent's home? ☐ No ☐ Yes, describe (including if meals or snacks are consumed):

Does your child spend any time at home with no adult present? ☐ No ☐ Yes, describe:

Nutrition

How many days per week (0-7) does your child eat:

Breakfast	Morning Snack	Lunch	Afternoon Snack	Supper	Evening Snack

Does your family eat meals together at the table? ☐ No ☐ Yes

If yes to the above question, how many times (0-7) per week?	Breakfast	Lunch	Supper

Approximately how many meals per week does your family eat from a restaurant/fast food/take out? _____

Who usually does the grocery shopping? _____

Who usually plans and prepares family meals? _____

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Do you have concerns about the amount of food that your child eats? ☐ No ☐ Yes, describe:

How long does it take your child to eat a meal (number of minutes)? _____

Are there any conflicts between family members about food? ☐ No ☐ Yes, explain:

(i.e., What is eaten? How much is eaten? When is it eaten?)

What is meal time typically like at home on a scale of 1 to 10?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
relaxed									stressful

Sleep, Physical Activity & Screen Time

What time does your child go to sleep? Weekdays _____ Weekends _____

What time does your child wake up? Weekdays _____ Weekends _____

Do you have any concerns regarding your child's sleep? ☐ No ☐ Yes, explain:

i.e., difficulty falling asleep or staying asleep, nightmares, sleepwalking, bedwetting, snoring

Do you feel as if your child is getting enough physical activity: ☐ No ☐ Yes ☐ Unsure

Does your child participate in activities outside of school? ☐ No ☐ Yes, list activities below:

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Approximately, how many hours *per day* does your child spend on screen time?

	Television	Computer	Video games	Smartphone/tablet	Total
Weekdays					0
	Television	Computer	Video games	Smartphone/tablet	Total
Weekends					0

What are your child's interests?

How does your child spend most of their free time?

Is there anything else you would like us to know about your family?

Thank you for taking the time to provide this valuable information.

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Consent and Acknowledgement Form

Read the consent and acknowledgement carefully. Consent must be signed by parent(s)/legal guardian(s).

I provide consent for my child, _____, to attend the Pediatric Centre for Weight and Health at the Misericordia Community Hospital for medical, physical, nutritional and mental health assessment and treatment about my child's weight.

I understand that this consent is effective upon signing and valid for two years. I further understand that I may revoke this consent in writing at any time and that revoking my consent will result in the assessments and treatment being discontinued.

ACKNOWLEDGEMENT

I acknowledge the following:

1. The Pediatric Centre for Weight and Health collects information directly from you, and may collect information from other health care professionals previously involved in your child's care for the purpose of providing you child with health services or other purposes under the Health Information Act. This collection of health information is authorized by the Health Information Act.

2. Covenant Health protects the confidentiality of the information relating to your child's treatment in the Pediatric Centre of Weight and Health and will only disclose health information without your consent to your regular doctor or as otherwise authorized by the Health Information Act.

We need both parents' signatures for consent to care, OR one signature and supporting legal documents regarding custody/decision making.

_____	_____
Printed name of Parent/Guardian	**Signature of Parent/Guardian**
_____	_____
Printed name of Parent/Guardian	**Signature of Parent/Guardian**

This consent and acknowledgment is signed on the _____day of _____, 20____.

If you have questions about the collection, disclosure, or privacy of your child's health information, contact the Child Health Clinic Manager at 780.735.9223 or by writing to:

231-Mother Rosalie HSC 16930 87 Avenue Edmonton, AB T5R 4H5

Permission to Discuss Research Studies

The Pediatric Centre for Weight and Health occasionally conducts research studies to help inform and improve the care that we provide to children and families.

If we have a current research study recruiting participants, do you give permission for a study investigator to discuss the study with you and your child?

This is only a permission form to discuss the research study with you. This is not a consent form to participate in the research, and you are under no obligation to participate in any research studies after discussing it with a study investigator.

☐ **Yes, I give permission** for a study investigator to discuss research studies occurring at the Pediatric Centre for Weight and Health for which my child or family may be eligible to participate.

☐ **No, I do not give permission** for a study investigator to discuss research studies occurring at the Pediatric Centre for Weight and Health for which my child or family may be eligible to participate.

Child's name _____ **Date** _____

Printed name of Parent/Guardian _____ **Signature of Parent/Guardian** _____

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Date (dd/mon/yyyy)	Client Code

Child & Youth Nutrition Survey

The survey was adapted from: Children's Dietary Questionnaire, Magarey, A. et al. (2009); PACE + Dietary Fat Screening Measure, Prochaska, J. et al. (2001); Beverage Snack Questionnaire, Neuhouser, M. et al. (2009).

Complete the following survey if you are the primary caregiver for your child or teen. If there are two primary caregivers, only one needs to complete the survey.

This survey will help your dietitian to get to know you better. Once you have completed the survey, provide the completed copy to your dietitian. Try to be as honest and accurate as possible – remember; there is no right or wrong answer. The entire survey should take about 15 minutes to complete.

Section 1: This section is about vegetables and fruit

Check all the listed foods your child/teen has eaten over the past seven days (one week).

Fruit (fresh, canned or frozen)

- ☐ Fruit salad
- ☐ Strawberries
- ☐ Orange
- ☐ Pineapple
- ☐ Peach
- ☐ Mango
- ☐ Blueberries
- ☐ Grapefruit
- ☐ Banana
- ☐ Melon
- ☐ Apple
- ☐ Kiwi
- ☐ Apricot
- ☐ Cherries
- ☐ Mandarin
- ☐ Nectarine
- ☐ Pear
- ☐ Plum
- ☐ Grapes
- ☐ Other

Vegetables (raw or cooked)

- ☐ Winter squash
- ☐ Carrot
- ☐ Cabbage
- ☐ Tomato
- ☐ Cauliflower
- ☐ Broccoli
- ☐ Corn
- ☐ Bell pepper
- ☐ Brussels sprouts
- ☐ Potato (not fries/hash browns)
- ☐ Peas
- ☐ Zucchini
- ☐ Sweet potato
- ☐ Green/yellow beans
- ☐ Spinach
- ☐ Bok choy/ Pak choi
- ☐ Lettuce
- ☐ Celery
- ☐ Cucumber
- ☐ Mushroom
- ☐ Eggplant
- ☐ Onion
- ☐ Sprouts
- ☐ Mixed vegetables
- ☐ Other

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Check off how often your child/teen has each of the following foods in the past 24 hours.

	None	Once	Twice	3 times	4 times	5+ times
Vegetables (raw or cooked)	○	○	○	○	○	○
Fruit (fresh, canned, frozen)	○	○	○	○	○	○

Check off how many different types of the following foods your child/teen has had in the past 24 hours.

	None	1	2	3	4	5+
How many different vegetables (raw or cooked)?	○	○	○	○	○	○
How many different fruits (fresh, canned, frozen)?	○	○	○	○	○	○

Check off the number of times your child/teen had the following foods over the past seven days (one week).

	None	1	2	3	4	5	6	7
How many days in the past week did you have some vegetables (raw/cooked)?	○	○	○	○	○	○	○	○
How many days in the past week did you have some fruit (fresh/canned/frozen)?	○	○	○	○	○	○	○	○

Continue to section 2

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Section 2: This next section is about beverages (or drinks)

How often did your child/teen drink these beverages over the past seven days (one week)?
(Mark one in each row.)

	Never or less than 1/week	1/week	2-4/week	5-6/week	1/day	2-3/day	4+/day
Orange juice, apple juice and other 100% juices	○	○	○	○	○	○	○
Fruit drinks (such as Snapple®, flavoured teas, Capri Sun® and Kool-Aid®)	○	○	○	○	○	○	○
Sports drinks (such as Gatorade® or PowerAde®); these drinks usually do not have caffeine	○	○	○	○	○	○	○
Flavoured waters (such as Propel® or vitamin waters); these drinks usually do not have caffeine	○	○	○	○	○	○	○
Regular soda or pop (include all kinds such as Coke®, Pepsi®, 7-Up®, Sprite®, root beer)	○	○	○	○	○	○	○
Slurpees/ slushies, iced cappuccino, frappuccino®	○	○	○	○	○	○	○
Energy drinks (such as Rockstar®, Red Bull®, Monster® and Full Throttle®); these drinks usually have caffeine	○	○	○	○	○	○	○
Flavoured milk (chocolate, strawberry, etc)	○	○	○	○	○	○	○
Regular or 2% milk (sometimes called whole, homogenized, reduced fat, or 4% milk fat; white milk)	○	○	○	○	○	○	○
1% or non-fat milk (sometimes called skim, fat free, or low-fat milk; white milk)	○	○	○	○	○	○	○
Water	○	○	○	○	○	○	○
Diet soda or pop (include all kinds such as Diet Pepsi®, Pepsi One®, Diet Coke®, Diet 7-Up®)	○	○	○	○	○	○	○

Continue to section 3

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Section 3: This next section is about food

Think about all the foods your child/teen ate over the **past seven days (one week)** as part of a meal or as a snack.

Check how often your child/teen ate each food item listed from "did not eat it this week" to "more than twice each day" over the past seven days (one week). (Mark one in each row.)

	Did not eat this food	1/week	2-3/week	4-6/week	1-2/day	3+/day
Hamburgers, beef tacos or burritos	○	○	○	○	○	○
Beef or pork, such as steaks, roasts, ribs, or in sandwiches	○	○	○	○	○	○
Fried chicken/ chicken nuggets/ chicken fingers, fried fish/fish sticks	○	○	○	○	○	○
Hot dogs or corn dogs	○	○	○	○	○	○
Lunch meats like ham or salami (not low-fat)	○	○	○	○	○	○
Bacon or sausage (breakfast, Farmer's, Polish, Italian)	○	○	○	○	○	○
Eggs, omelet, quiche (not egg substitute)	○	○	○	○	○	○
Pasta with meat sauce	○	○	○	○	○	○
Pizza with meat toppings	○	○	○	○	○	○
Pizza with cheese	○	○	○	○	○	○
Pasta with cheese or cream sauce	○	○	○	○	○	○
Whole or 2% milk	○	○	○	○	○	○
Ice cream, milkshake (not frozen yogurt)	○	○	○	○	○	○
French fries, tater tots, onion rings	○	○	○	○	○	○
Potato chips, tortilla chips, buttered popcorn	○	○	○	○	○	○
Cake, cookies, brownies, candy bars	○	○	○	○	○	○
Doughnuts, pastries, muffins	○	○	○	○	○	○

	Did not eat this food	1/week	2-3/week	4-6/week	1-2/day	3+/day
Cheese or cheese spread (Cheez Whiz)	○	○	○	○	○	○
Regular margarine or butter (not diet or light)	○	○	○	○	○	○
Salad dressings, mayonnaise (not diet or lite)	○	○	○	○	○	○
Peanut butter, other nuts, sunflower seeds	○	○	○	○	○	○

Section 4: This section is about mealtimes and eating

Check off the best answer for each question.

	None	1 day	2 days	3 days	4 days	5 days	6+ days
How many times a week does your child/teen eat breakfast?	○	○	○	○	○	○	○
How many times a week does your child/teen and your family sit at a dinner table to eat supper?	○	○	○	○	○	○	○
How many times a week does your child/teen eat a meal or snack in front of the T.V.?	○	○	○	○	○	○	○
How many times a week does your child/teen help with preparing/making a meal?	○	○	○	○	○	○	○

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Check off the best answer for each question.

	Never	Rarely	Sometimes	Often	Always
How often do you encourage your child/teen to finish everything on his/her plate?	○	○	○	○	○
How often do you notice your child/teen is hungry within one hour after eating a meal/snack?	○	○	○	○	○
Do you use the nutrition facts table when grocery shopping?	○	○	○	○	○

Let your dietitian know if any of the questions on this survey made you feel uncomfortable or did not make sense.

Thank you for your time. This survey will not only help us to provide the best care possible for your family, but it will help us provide a better service for future families to come.

Write any comments you have:

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Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
○	○	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
○	○	2.	**Do you feel pain in your chest when you do physical activity?**
○	○	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
○	○	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
○	○	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
○	○	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
○	○	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Supported by: Health Canada Santé Canada

1:12

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