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Robert Wood Johnson
Medical Group
ROBERT WOOD JOHNSON MEDICAL SCHOOL
Department of Pediatrics
Healthy ME: Pediatric Lifestyle Changes Program
Karen L. Leibowitz, MD
Amy Faus, MPH
Melanie Kim, MS, RD
OFFICE: 732-235-7541
SCHEDULING: 732-235-6230 x5

Healthy ME: Pediatric Lifestyle Changes Program

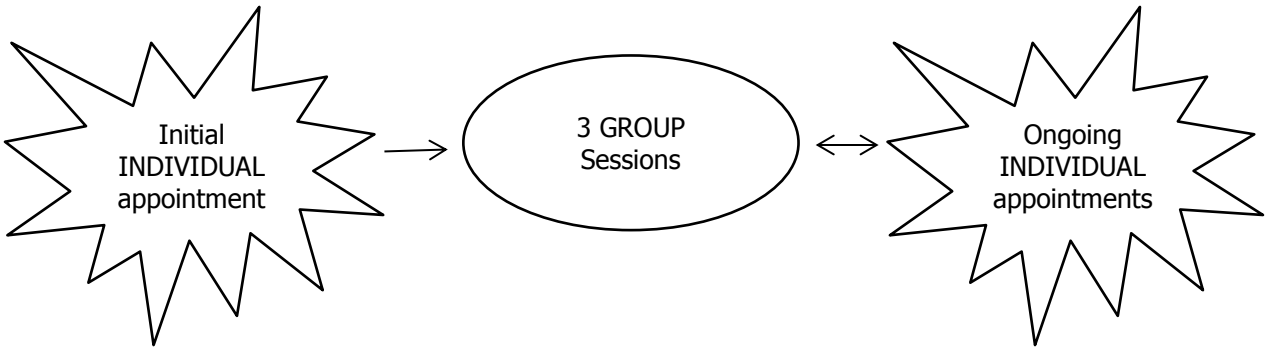
Dear Patient and Family:

We are excited to learn that you are interested in our family-centered **lifestyle changes program.** Weight issues for children, including medical, emotional and physical problems, are becoming an increasing concern. Healthy ME will help you and your family make lifestyle changes to work through these issues.

Healthy ME is a very **flexible** program. It is **individualized** to fit your personal needs. You and your family will work with a doctor, a registered dietician, and a program coordinator to feel happier, healthier, and stronger. Together, we will learn about healthy eating and physical activity and figure out how healthy habits fit your lifestyle. You will decide the focus and direction of the appointments; we will provide the support.

We want to make sure that this program is a good fit for you and your family. Below is an overview of the program so that you know exactly what to expect from Healthy ME.

Program Flow



Group Sessions

Following an initial appointment, you will attend a few group sessions that will:

- Build a strong foundation to support your future individual Healthy ME goals
- Introduce strategies for approaching challenges
- Provide essential nutrition education
- Offer the opportunity to meet other families in the program

Individual Appointments

Once you have gained a foundation of knowledge by attending group sessions, you will attend ongoing one-on-one appointments with the Healthy ME team. These appointments will include:

- Medical management
- Goal-setting for healthy lifestyle changes
- Strategizing to achieve goals
- Tracking previous goals
- Addressing barriers to making changes
- Working as a family to develop lifelong healthy habits

Before Scheduling Your First Visit, you need to do the following:

- ❑ Complete and send us the blood work results
  - o Give the lab checklist to your referring doctor so that he/she can order the blood work we need. (The attached list is not a prescription).
- ❑ Fill out and send us the Initial History Form (attached)
- ❑ Fill out and send us the 3 day food record (attached)

Once these 3 items are received, we will contact you to schedule an appointment.

Cancellation/No Show Policy:

Because many families are interested in being a part of this program, we need to maintain a strict cancellation and no show policy. If you can't keep your appointment, please give us at least **48 hours' notice**. If you do not show or cancel more than one appointment in a row, you not be able to continue with the program.

Contact Information:

Office: 732-235-7541
Scheduler: 732-235-6230 (option 5)

Please let us know if you have any questions. We look forward to meeting you and your family.

Sincerely,

Karen L. Leibowitz

Karen L. Leibowitz, MD
Pediatric Gastroenterology and Nutrition

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Appointment Checklist

There are 3 steps you need to complete before you schedule your first appointment:

- ❑ **Step 1:** Blood work results (have your doctor order the list on page 4)
- ❑ **Step 2:** Initial History Form (attached, pages 5-12)
- ❑ **Step 3:** Three day food record (attached, pages 13-16)

Please mail or fax these completed forms to:

Healthy ME: Pediatric Lifestyle Changes Program
Department of Pediatrics
Rutgers, Robert Wood Johnson Medical School
89 French St, Rm 2360
New Brunswick, NJ 08901
Fax: 732-235-6381

Healthy ME: Pediatric Lifestyle Changes Program

Step 1: Lab Checklist

Please **ask your doctor to order the following blood work and to fax the results to our office**. These results are required before you can schedule your initial visit. When you get these labs, your child should **not be sick** for at least two weeks.

Fax: 732-235-6381
Attention: Dr. Karen Leibowitz

Laboratory Studies: **Fasting** (nothing to eat or drink after midnight)

CMP
CBC
Free T4
TSH
Lipid panel
Insulin and C-peptide
HgBA1C
Vitamin D 25 Hydroxy Level

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Step 2: Initial History Form

Healthy ME: Pediatric Lifestyle Changes Program

Today's date: _____

Name of Child: _____

Date of Birth: _____ Age: _____ Gender: ☐Male ☐Female

Ethnicity: _____

Name of person completing form (we would prefer caregiver and child to complete form together):

_____

Relationship of caregiver to patient: _____

Who will be coming to the clinic with the patient? _____ (must be parent/legal guardian)

Language preferred for child: _____ and for caregiver: _____

Address: _____

_____

Phone #: _____ Cell #: _____

Who lives at home with your child? _____

What family and/or friends are actively involved in your child's life but do not live with them?

_____

_____

Name and Telephone Number of Pediatrician/Family Physician: _____

Does your child see other pediatric specialists? ☐Yes ☐No

If yes, please list the doctors' names and why your child sees them:

_____

_____

_____

Who referred you to this program? _____

What would you like to get out of joining Healthy ME? _____

_____

How old was your child when your child's doctor became concerned about his/her weight? _____

How old was your child when you became concerned about his/her weight? _____

What is the most your child has weighed in pounds? _____

At what age did your child get to that weight? _____

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

What factors do you feel contribute to your child's weight gain both in the present and the past?

_____

What concerns you the most about your child's health and weight?

_____

How would you describe how important it is for you right now to help your child control their weight?

Please circle:

Not at all important Unsure Important Extremely important

How would you describe how confident you are that you can help your child change their weight?

Please circle:

Not at all confident Unsure Confident Extremely confident

What are some of your biggest challenges when it comes to making a healthy change at home?

_____ _____ _____

_____ _____ _____

What are the most important things you would like help with?

_____ _____ _____

_____ _____ _____

What are some of the following behaviors that your child may do?

Please circle all that apply:

binge eating	eating in bedroom	eating in front of TV/computer/video games
sneaking food	emotional eating	feeling out of control with eating
laxative abuse	night eating	

What has been tried to help your child to control their weight?

Please put T for Tried and W for Worked.

attending behavioral weight management program ____ attending weight loss camps ____

eating less fast food ____ eating less snacks ____

eating low carbohydrate foods ____ eating low-fat or non-fat foods ____

decreasing or stopping juice, soda, iced tea ____ eating more fruits or vegetables ____

smaller servings at meals____ skipping meals ____

specific diets ____ increase exercise ____

counseling by nutrition professional ____ medicines for weight loss ____

working with pediatrician ____ Others: _____

Diet History

Who purchases and prepares your child's meals and snacks? **Please circle:**

parent child other caregiver

Does your child eat school lunch? ☐Yes ☐No

If yes, what are some of the typical foods your child eats?

_____ _____ _____

_____ _____ _____

What is the average length of time it takes your child to finish a meal? **Please circle:**

5 minutes or less 10 minutes 15-20 minutes greater than 20 minutes

How many meals *per day* does your family eat together? **Please circle:**

None 1-2 meals all meals

How would you describe mealtimes together with your child? **Please circle:**

Always pleasant Usually pleasant Sometimes pleasant Never Pleasant

On average, how many meals *per week* does your child eat fast food? **Please circle:**

0-2 3-5 greater than 5

On average, how many meals *per week* does your child eat from an outside food establishment (take-out or restaurant)? **Please circle:**

0-2 3-5 greater than 5

Past Medical History

Pregnancy and Birth History

Was your child born on time (full term)? ☐Yes ☐No If No, how early? _____

Birth weight: _____pounds _____ounces Birth Length: _____ inches

Did mom have diabetes during pregnancy? ☐Yes ☐No

If yes, did she need insulin? ☐Yes ☐No

Did mom smoke during pregnancy? ☐Yes ☐No

Did mom drink alcohol during pregnancy? ☐Yes ☐No

Did mom have high blood pressure during pregnancy? ☐Yes ☐No

Did mom have high cholesterol during pregnancy? ☐Yes ☐No

What was mom's weight before pregnancy? _____ pounds

How much weight did mom gain during pregnancy? _____pounds

Did mom have any complications during pregnancy? ☐Yes ☐No

If yes, please explain _____

Did the baby have any complications during pregnancy? ☐Yes ☐No

If yes, please explain _____

Other pregnancy info? _____

Did your child have any issues at birth? _____

Was your child born vaginally or by c-section? _____

Were there any complications during or after the delivery? ☐Yes ☐No

If yes, please explain _____

Did your child need to go to the NICU? ☐Yes ☐No If yes, for how long?_____

If yes, for what problems?_____

Was your child breastfed? ☐Yes ☐No If yes, for how long/until what age? _____

At what age did your child start formula? _____

At what age did your child start taking solid foods? _____

Developmental History

Has your child had any developmental delays (feeding, walking, talking, etc.)? ☐Yes ☐No

If yes, please explain: _____

Has your child received any special services, such as physical therapy, feeding therapy, occupational therapy or speech therapy? ☐Yes ☐No

If yes, please explain: _____

Does your child have any of the following? **Please circle**: Autism ADHD Learning disabilities

Has your child ever been hospitalized? ☐Yes ☐No If yes, date or age: _____

Reason: _____

Has your child ever had any surgery? ☐Yes ☐No If yes, date or age: _____

Reason: _____

Does your child take any prescription medicine? ☐Yes ☐No

If yes, name:_____ Reason _____

If yes, name:_____ Reason _____

If yes, name:_____ Reason _____

Does your child take any non-prescription medicine (for example: vitamins, herbal therapies or laxatives)?

☐Yes ☐No

If yes, what? _____

Does your child have any allergies to foods or medications? ☐Yes ☐No

If yes, list allergies: _____

For Females

Age when menstrual periods first started: _____

How often does she get her period? _____ How long does her period last? _____

Does she get cramps with her periods? ☐Yes ☐No

If yes, does she take any medications for the cramps? ☐Yes ☐No

If yes, list the medication: _____

What was the date of her last period? _____ What was the date of the period before that? _____

Past Medical History

Does your child have any chronic health conditions?

Please circle all that apply:

Depression	Pseudotumor cerebri	Asthma
Obstructive sleep apnea	Reflux	Constipation
Gallbladder disease	Elevated liver enzymes	Fatty Liver
Joint problems	Thyroid problems	Bowing of the legs (Blount disease)
Polycystic ovarian syndrome	Type 2 diabetes	High blood pressure
High cholesterol	OTHER: (please state) _____	

Review Of Systems

Has your child had or does your child have any of the following?

Please circle all that apply:

abdominal pain	acne	anxiety
attention problems	behavior problems	binge eating
blurred vision	burping	chest pain
constipation	dental caries	depression
diarrhea	dizziness	excessive body hair
excessive thirst	excessive urination	fatigue
gasping while asleep	headaches	heartburn
learning problems	limping	menstrual irregularities
migraines	mood swings	nausea
other skin problems	overly sleepy during the day	pain or swelling in joints
palpitations	problems with falling asleep	problems with staying asleep
regurgitation	sadness	shortness of breath with activity
sore throat	snoring	weak muscle
wheezing with activity		

Family History

Has anyone in your family (child's parents, brothers or sisters, maternal/paternal grandparents, aunts and uncles) had any of the following health problems? Please list which family member(s) has the condition:

Overweight _____

Weight loss (Bariatric) surgery _____

Obesity _____

Smoking _____

Diabetes _____

Cancer _____

Chronic Headaches _____

High blood pressure _____

High cholesterol _____

High triglycerides _____

Heart attack before age 60 _____

Stroke_____

Thyroid problem _____

Gallbladder disease _____

Fatty Liver _____

Constipation _____

Reflux_____

Joint problems _____

Asthma _____

Obstructive sleep apnea (snoring) _____

Psychological problems _____

Polycystic Ovarian Syndrome _____

Eating disorder (anorexia nervosa or bulimia nervosa) _____

Binge eating disorder _____

Other: _____

Has anyone in the family been in a weight management program? ☐Yes ☐No

If yes, please describe:_____

Has anyone in the family been on a diet? ☐Yes ☐No

If yes, please describe:_____

What is the child's mother's current weight ? _____ height? _____

What is the child's father's current weight? _____ height? _____

What are siblings (brothers/sisters) current weight / height

_____ current weight? _____ height? _____

_____ current weight? _____ height? _____

_____ current weight? _____ height? _____

_____ current weight? _____ height? _____

_____ current weight? _____ height? _____

_____ current weight? _____ height? _____

Social History

What grade is your child in? _____

How is he/she doing academically?

☐ Excellent grades ☐ Above average grades ☐Average grades

☐ Having problems or failing some classes ☐ Not in school ☐ Home school

How is your child doing socially **(check all that apply)**?

☐ Does fine, has friends ☐ Often alone or lonely

☐ OK, would like more friends ☐ Frequent fights/arguments with other children

☐ Teased or bullied (why? _____)

Please list any stressors or recent changes at home or school (for example: moving, unemployment, divorce, illness/death in the family, etc.): _____

To help us serve your family, please mark the highest level of education completed by the child's **parent**:

☐ Less than high school ☐ High school ☐ Some college ☐ College or higher

What is your family's estimated annual income?

☐ Less than $10,000 ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$39,999

☐ $40,000-$59,999 ☐ $60,000-$79,999 ☐ $80,000-$99,999 ☐ $100,000 or higher

List hobbies or interests your child has--things that he/she likes to do at school, after school, or at home:

_____ _____ _____

_____ _____ _____

How would you describe your child's usual mood? _____

Has your child ever gotten any counseling (psychologist, psychiatrist or social worker)? ☐Yes ☐No

If yes, reasons for counseling: _____ Did it help? ☐Yes ☐No

Has your child been diagnosed with any of the following?

☐ Depression ☐ Anxiety ☐ ADHD/ADD ☐ Bipolar disease ☐ OCD

☐ Oppositional defiant disorder ☐ Borderline disorder ☐Other

If so, please describe: _____

Goals

What goals do you have for your child in participating in this program **(check all that apply)**?

- ☐ Weight loss (how many pounds would you like him/her to lose? _____)
- ☐ Keep weight the same/stop gaining
- ☐ Get more in shape physically
- ☐ Feel better about him/herself
- ☐ Decrease health complications or risk for them
- ☐ Become more social
- ☐ Do better in school
- ☐ Improve mood and energy

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Step 3: Food Record

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Food Record Instructions

Please record all food and beverages for 3 full days. The days do not have to be consecutive; if an unusual day arises which does not reflect you or your child's usual intake, do not record that day. Make sure you include at least one weekend day. The goal of this food record is to get an accurate picture of what and how much you or your child is eating. It is very important that you write down **everything** that you or your child eats and drinks and the amounts. The following pointers will help you:

1. Record immediately after the meal or snack; **do not wait until the end of the day.** Include the time of day and the meal at which the food is eaten. Please also specify the **place** where you ate your meal and snack, such as "at the dinner table" or "in my room."

2. Describe the food or beverage as accurately as possible:

   - For prepared foods, **give brand names** such as Hellmann's Mayonnaise, or General Mills Fiber One cereal. Include food labels with the food record whenever possible.

   - For fruits and vegetables, indicate if fresh, frozen, canned or dried, e.g., "canned peach slices in heavy syrup, frozen green beans, dried apple slices or fresh apple with skin".

   - Indicate **how the food was cooked** (e.g. "fried chicken or baked potato"); Include the recipe if you have one.

3. Specify **types** and **amounts** of food or beverage consumed. **Indicate how big the serving, cup, bowl, piece or slice is.** For fluids: Write # of fluid ounces, e.g. 4 fl. Oz. orange juice or 2 oz 1 % milk. For solid foods: Use common household measurements, e.g. 1 tsp butter, 1 Tb mashed potato, 1 oz meat or cheese, A ½ cup ziti with 2 Tb. spaghetti sauce. Also, write size of food amount eaten, Ex. "1 two-inch chocolate chip cookie", A ½ slice white bread, a ¾ cup bowl Campbell's chicken noodle soup, 15 green grapes, 2 one-inch meatballs, or 1 jelly bean. You can also weigh foods or estimate the weight of foods eaten from the information on the food label or you can draw actual size of portion.

4. Include amount of sauces, salad dressings, butter, condiments and any other additives.

5. Please describe your **mood** before and after each meal and snack, such as feeling, excited, sad, happy, bored.

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NAME_____ DATE_____

TIME/MEAL	FOOD/BEVERAGE DESCRIPTION	AMOUNT

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NAME_____ DATE_____

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