

Welcome to The Healthy Active Living Program

This is the beginning of your journey to a healthy, active lifestyle.

Congratulations on making the decision to take the first step towards a happier, healthier, and more active way of life! We are excited to help you make **healthy lifestyle changes** and find the **energy balance** you need to become a healthier you.

Change is not easy. It takes commitment, hard work, resilience, and support. And who better to support us than the ones we love! That is why **we strongly encourage making these lifestyle changes as a family** to improve your chances for success.

There will be highs and lows as you proceed on your journey. No matter what, you and your family must **stay committed to your goals** to maintain your healthy lifestyle changes. **Consistent participation** in the program is **key** in maintaining lifestyle changes and reaching your goals.

Your family will get six total visits, which will include a combination in person as well as virtual/phone follow ups, every 4-6 weeks during your time in the program. Your team will include **a physician, behavioral therapist and dietician**, who will work together and support you throughout this journey. After each appointment, you will leave with goal(s) to work on before your next visit. **The key to success is your promise to yourself to work on each of your goals every day.**

This program is about learning a healthy lifestyle and is not considered a “diet” or weight loss program. Each family will receive a 3-month and a 6-month follow-up visit to make sure that the healthy habits persist. There will also be physical activity and cooking class opportunities for your family.

Your journey begins now...and we know you will succeed!

The Healthy Active Living Team

Locations & Contact Information

Advocate Children's Hospital – Oak Lawn
4440 W. 95 th Street, Suite 1200H, Oak Lawn, IL 60453
Provider: Dr. Jeremy Daigle
Office Hours: Wednesday afternoons and all day last Wednesday of the month.
Call (708) 684-KIDS & press OPTION 1 to schedule an appointment

Chicagoland Children's Health Alliance Pediatric Outpatient Center
3232 Lake Avenue #330, Wilmette, IL 60091
Provider: Dr. Lori Walsh
Office Hours: Thursdays
Call (847) 318-9330 to schedule an appointment

What to Expect

- Personalized visits with a doctor, dietitian and behavior counselor for nutrition, physical activity and behavior modification counseling
- 45-90 minute visits, depending on how many providers you see that day. Please plan accordingly.
- In-person and virtual visits every 4-6 weeks for 6 visits. Frequency and duration of visits are based on your family's needs.
- An assessment of your child's risk for medical conditions associated with excess weight
- Cooking classes and physical activity opportunities

Patient Late Policy

Our primary goal is to provide exceptional service to our patients. In order to do so, we ask that you arrive on time for your appointment. The Healthy Active Living Care Team has dedicated time to spend with each family. For that reason, we ask you to familiarize yourself with our no show and cancellation policy below:

Patient No Show and Cancellation Policy

So we can serve you better, please notify the Healthy Active Living location **24 hours** in advance to cancel or change your appointment. Please call the office to cancel or to change your appointment. Patient may potentially be discharged from program or have to go to bottom of waiting list for a new appointment if they have:

- Two consecutive no show appointments
- Two consecutive cancellations within 24 hours of their appointment
- A combination of three consecutive no shows or cancellations made within 24 hours of their appointment.

It is important to attend your appointments as scheduled to receive full benefit from this program.

We look forward to a great partnership with you and your family on your path to improved health and wellness.

Healthy Active Living Program Intake New Patient Intake Form

Patient

Patient's Legal Name (Last, First, Middle)

Date of Birth

Age

Sex

Race

Ethnicity

Home Address

City

State

Zip Code

Parent's Name & Preferred Phone Number (indicate home/mobile/work)

Background and Medical Information

1. Background Information

Your Child's Primary Doctor:

Doctor's Phone:

How did you hear about the Healthy Active Living Program?

Who referred you to the Healthy Active Living Program?

2. History of Current Problem

What is your main concern about your child's health?

At what age did weight become a concern?

What do you hope to learn from your first appointment with us?

Are you interested in learning more about weight loss surgery? ☐ Yes ☐ No

3. Birth History

Pregnancy Complications:

☐ Yes ☐ No

Blood sugar/problems/Gestational Diabetes: ☐ Yes ☐ No

Birth Weight:

Premature Birth: ☐ Yes ☐ No If yes, how early?

Any breastfeeding?

☐ Yes ☐ No

If yes, how long:



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4. Past Medical History

Immunizations up to date: ☐ Yes ☐ No

Food Allergies: ☐ Yes ☐ No If yes, list:

Medication Allergies: ☐ Yes ☐ No If yes, list:

Hospitalizations: ☐ Yes ☐ No If yes, list:

Mental Health Hospitalizations: ☐ Yes ☐ No

Has your child ever received testing for a learning disability or developmental delay? ☐ Yes ☐ No

Has your child ever been referred for mental health counseling? ☐ Yes ☐ No

Right now, is your child seeing a psychologist, counselor, psychiatrist or therapist? ☐ Yes ☐ No
If yes, please list names of providers:

Does your child have any of the following conditions:

ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	GI Reflux <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Polycystic Ovarian Syndrome (PCOS) <input type="checkbox"/> Yes <input type="checkbox"/> No
Celiac Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunologic Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	Inflammatory Bowel Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Delay <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Learning Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Sugars (Prediabetes) <input type="checkbox"/> Yes <input type="checkbox"/> No	Individualized Education Plan/504 Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	

Other:

Please list any other doctors that your child sees:

Please list your child's medications, vitamins and supplements and dosages:

5. Current Medical Review (Check all that apply)

Excessive thirst? ☐ Yes ☐ No

Low energy during the day? ☐ Yes ☐ No

Frequent urination? ☐ Yes ☐ No

Bed wetting? ☐ Yes ☐ No

Males: Breast development? ☐ Yes ☐ No



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5. Current Medical Review (Check all that apply) Continued

Females: Age at first period? _____ Date of last period? ____/____/____

How long do the periods last? _____ Are they heavy, long or irregular? ☐ Yes ☐ No

Excess hair? ☐ Yes ☐ No If yes, where?

Knee Pain: ☐ Yes ☐ No

Hip Pain: ☐ Yes ☐ No

Foot Pain: ☐ Yes ☐ No

Sleep

Time to bed: (Weekday) _____ (Weekend) _____

Take naps: ☐ Yes ☐ No

Wake up time: (Weekday) _____ (Weekend) _____

If yes, how many days per week? _____

Hours of sleep: (Weekday) _____ (Weekend) _____

How long? _____

Snoring? ☐ Yes ☐ No

Any gasping/pausing/choking while asleep? ☐ Yes ☐ No

Trouble staying awake during the day? ☐ Yes ☐ No

6. Social History

Sometimes it is helpful for us to know who lives in the child's home(s). Please list all household(s) members.

Name	Relationship to Child	Age	Name	Relationship to Child	Age

Does your child split time between two or more households? ☐ Yes ☐ No

Smoking in home: ☐ Yes ☐ No

Highest level of education achieved by Mother:

- ☐ Less than high school
☐ Completed high school/GED
☐ Some college or associate degree
☐ Bachelor's Degree ☐ Graduate Degree

Highest level of education achieved by Father:

- ☐ Less than high school
☐ Completed high school/GED
☐ Some college or associate degree
☐ Bachelor's Degree ☐ Graduate Degree

Who is responsible for the grocery shopping?

Pets in home: ☐ Yes ☐ No

Who is responsible for the cooking?

Your child's grade level:

Does your child receive snacks, food or drinks from other caregivers or After Care Program? ☐ Yes ☐ No

If yes, from whom? _____ When does this happen? _____

Within the past 12 months, the food we bought just didn't last, and we didn't have money to get more.

☐ Sometimes True ☐ Never True ☐ Often True

Within the past 12 months, we worried that our food would run out before we had money to buy more.

☐ Sometimes True ☐ Never True ☐ Often True



7. Family Medical History (Check all that apply)

Family Medical History (Relationship to Child)	Mother	Father	Sister	Brother	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother	Grandma (Mom's Mom)	Grandpa (Mom's Dad)	Grandma (Dad's Mom)	Grandpa (Dad's Dad)
Anxiety Disorder												
ADHD												
Asthma												
Cancer/Leukemia												
Celiac Disease												
Depression												
Diabetes												
Environmental Allergies												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Immunologic Disease												
Inflammatory Bowel Disease												
Joint Disease												
Kidney Disease												
Learning Difficulties												
Liver Problems												
Migraine Headaches												
Myocardial Infarction/Heart Attack												
Reading/Writing Difficulties												
Seizure Disorder												
Sleep Apnea												
Stroke												
Sudden Death (heart)												
Thyroid Disease												
Obesity												

My signature below confirms that I have completed this form and I have read and fully understand the Patient Late and Patient No-Show/Cancellation Policies.

Date

Time

Parent or Legal Guardian Signature

