Welcome to the Strong4Life Clinic at Children's Healthcare of Atlanta.

We are looking forward to meeting and working with your family.

Please help us better serve you and your child by reviewing, completing and returning the paperwork in this packet. We know the packet is long, but please do your best to complete as much of the information as possible.

Once we receive your packet, we will contact you to set up your first appointment with our team.

As a reminder, we are located on the 6th floor of the Children's Center for Advanced Pediatrics building. If you have any questions, concerns or difficulties completing the packet, please contact us.

Thank you.

Strong4Life Clinic, a department of Children's at Scottish Rite

Center for Advanced Pediatrics
1400 Tullie Road NE
6th Floor
Atlanta, GA 30329
Phone: 404-785-KIDS (5437)
Fax: 404-785-1511
Email: Strong4LifeClinic@choa.org
Strong4Life.com/Clinic

New Patient Intake Form

Patient

Patient's Legal Name (Last, First, Middle)			Date of Birth
Age	Sex	Race/Ethnicity	Religion
Home Address			
City		State	Zip Code
Preferred Phone Number			

Father/Guardian

Father's Name			Date of Birth
Address (if different from above)			
City		State	Zip Code
Home Number	Cell Number	Work Number	

Mother/Guardian

Mother's Name			Date of Birth
Address (if different from above)			
City		State	Zip Code
Home Number	Cell Number	Work Number	

Emergency Contacts *(other than listed above)*

Name	Phone Number	Relationship to Patient

Insurance Information

Please complete the information below about your child's insurance coverage.

Everything can be found by looking at your current insurance card.

Feel free to make a copy of the front and back of your insurance card to include in the packet instead.

Primary Insurance		
Insurance Company's Name	Plan Name	
Insurance Subscriber's Name	Subscriber's Date of Birth	Relationship to Patient
Employer	Group Name	Phone Number
Subscriber/Member ID	Address Listed	
Group Number		
Secondary Insurance		
Insurance Company's Name	Plan Name	
Insurance Subscriber's Name	Subscriber's Date of Birth	Relationship to Patient
Employer	Group Name	Phone Number
Subscriber/Member ID	Address Listed	
Group Number		

Important Billing and Insurance Information

You or your insurance company will receive, at a minimum, two bills. One bill will be for hospital services rendered as part of your visit (includes facility charge, labs, radiology and therapies) and the others will be for each doctor your child sees at the visit.

Separate co-payments or deductibles for which you are responsible may be applied to each bill, depending on your individual arrangement with your insurance company. If your child sees multiple doctors at your visit, you may be required to pay co-payments for each doctor seen.

In some cases, you may receive a bill from your doctor's private office.

Please feel free to contact us with any questions.

Phone number: 404-785-5437 (KIDS)

Fax number: 404-785-1511

Email: Strong4LifeClinic@choa.org

Background and Medical Information

Today's Date:

1. Background Information

Your Child's Primary Doctor:	Doctor's Phone:
How did you hear about the Strong4Life Clinic?	Who referred you to the Strong4Life Clinic?

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?

4. Past Medical History

Immunizations up to date: ❍Yes ❍No	Food Allergies: ❍Yes ❍No If yes, list:
Medication Allergies: ❍Yes ❍No If yes, list:	
Operations or Surgeries: ❍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	❍Yes ❍No	GI Reflux	❍Yes ❍No	Liver Problems	❍Yes ❍No
Anxiety Disorder	❍Yes ❍No	Heart Disease	❍Yes ❍No	Migraine Headaches	❍Yes ❍No
Asthma	❍Yes ❍No	High Blood Pressure	❍Yes ❍No	Polycystic Ovarian Syndrome *(PCOS)*	❍Yes ❍No
Celiac Disease	❍Yes ❍No	Immunologic Disease	❍Yes ❍No		
Depression	❍Yes ❍No	Inflammatory Bowel Disease	❍Yes ❍No	Seasonal Allergies	❍Yes ❍No
Developmental Delay	❍Yes ❍No	Kidney Disease	❍Yes ❍No	Seizure Disorder	❍Yes ❍No
Diabetes	❍Yes ❍No	Learning Difficulties	❍Yes ❍No	Sleep Apnea	❍Yes ❍No
High Blood Sugars *(Prediabetes)*	❍Yes ❍No	IEP (Education Plan)/504 Plan	❍Yes ❍No	Thyroid Disease	❍Yes ❍No

Other:
Please list the other doctors that your child sees:
Please list your child's medications, vitamins and supplements and dosages:

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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	

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

How long do your 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
Diagnosed with Blount's Disease: ❍Yes ❍No	Diagnosed with hip problems/SCFE: ❍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.*

Relationship to Child	Age	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 either parent/guardian? ❍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:
What type of school does your child attend? ❍Private ❍Public ❍Charter ❍Online ❍Homeschool ❍Daycare ❍Other:	Is your child in an After Care Program? ❍Yes ❍No

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

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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												
Reading/Writing Difficulties												
Seizure Disorder												
Sleep Apnea												
Sudden Death (heart)												
Thyroid Disease												
Weight Gain												

8. Are any of the following statements true for your child?	YES	NO
My child is always thinking about the next meal or snack. He or she never seems to be satisfied.		
My child uses food as a way to cope with stress or emotions.		
My child sneaks food, eats in secret, or overeats when I am not around.		
My child often says negative things about his or her body.		
My child has tried to lose weight by taking diet pills, laxatives, or water pills.		
My child has tried to lose weight by throwing up on purpose after eating.		
I noticed my child started gaining weight during a stressful time in his or her life.		
When my child has money, he or she spends it on food.		
My child and I argue about when, what, or how much he or she is eating.		
My child avoids eating in front of other people.		
My child is being teased/bullied.		
I noticed my child avoids being active or exercising in front of other people.		
My child has an opportunity to be active during the school day (P.E. or recess).		
My child used to play and enjoy organized sports but does not anymore.		
My child prefers to use electronics than free play outside.		
My child and I argue about limits on screen time.		
Would you like to see changes in your child's activity levels and screen time? If yes, please explain.		
Would you like to see changes in your family's eating habits? If yes, please explain.		

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 Strong4Life Clinic Care Team has dedicated time to spend with each family. For that reason, we ask you to familiarize yourself with our late policy:

- **Patients who are late to their appointment will see available team members as time permits. They are NOT guaranteed to meet with every provider on the Care Team.**
- **Patients who prefer to see the entire Care Team have the option to reschedule their appointment for another day.**

Patient No Show and Cancellation Policy

Your health is important to us, and we are always concerned when someone misses an appointment without prior notice. If you cancel at least 72 hours (3 days) before your appointment, we are then able to offer that appointment to another family. Please call us to reschedule your appointment, so that we can address your needs in a timely manner.

Families will require a new referral from their Pediatrician prior to obtaining 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.**

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

I have read and fully understand the Patient Late and Patient No-Show/Cancellation Policies.

Parent/Guardian Signature _____ Date _____