DATE OF VISIT:			
PATIENT'S NAME (Last, First, Middle):			
Birth Date: / /	Age:	Sex: ❑ M ❑ F	Hometown:
Current level of education:			
Who else lives with patient?			
Street address:			
Apt/Unit #	City:	State:	ZIP Code:
Parent/Guardian #1 Name:		Occupation:	
Address (if different from child's):			
CIRCLE PREFERRED MODE OF CONTACT:			
Email:			
Home:	Mobile:	Work:	
Parent/Guardian #2 Name:		Occupation:	
Address (if different from child's):			
CIRCLE PREFERRED MODE OF CONTACT:			
Email:			
Home:	Mobile:	Work:	

WHO REFERRED YOU TO US?

PHARMACY		
Name and location:	Phone:	
CURRENT or PREVIOUS DOCTOR(S)		Would you like us to request records from this doctor?
Name and Specialty:	Phone:	☐ Yes ☐ No
Name and Specialty:	Phone:	☐ Yes ☐ No
INSURANCE		
Primary Insurance:	Subscriber's #:	Group #:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Advanced Health or the insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

HEALTHY HABITS SURVEY

I am interested in your health and well-being. Please take a moment to answer the following questions.

Patient's Name: _____ Age: _____ Date: _____

1. How many servings of fruits or vegetables does your child eat every day? _____
   (1 Serving = size of your child's palm)

2. How many times a week does your child eat dinner together with the family? _____
3. How many times a week does your child eat breakfast? _____
4. How many times a week does your child eat food purchased outside (i.e., at a restaurant, take-out, fast food)? _____
5. How many hours a day does your child spend watching TV/movies or with Electronics (i.e., Smartphone, IPad, computer, video games)? _____
6. How many times a week does your child watch TV or play with electronics prior to going to sleep? _____
7. How much time does your child spend in active play each day? (faster breathing/heart rate or sweating) _____
8. How many cups of the following does your child drink in a day?
   Fruit juice _____ Sports drinks (i.e., Gatorade) _____ Soda or punch _____
   Water _____ Milk _____; What type of milk? _____

Based on your answers, what are the thing(s) you would like to help your child change now? Please check each box.

- ☐ Eat more fruits and vegetables
- ☐ Drink less fruit juice, soda, or punch.
- ☐ Drink more water.
- ☐ Spend less time watching TV/movies and/or on electronics
- ☐ Engage in more active play