



PE4ME STUDENT INTAKE FORM

DATE: _____

STUDENT ID #: _____

DOB: _____

GRADE: _____

SCHOOL ID #: _____

PRIMARY LANGUAGE: ¹ ENGLISH ⁵ VIETNAMESE

GENDER: M ¹ F ²

² SPANISH ⁶ JAPANESE

ETHNICITY: ¹ AFRICAN AMERICAN ⁴ CAUCASIAN

³ KOREAN ⁷ OTHER

² ASIAN/PACIFIC ISLANDER ⁵ HISPANIC

⁴ CHINESE

³ NATIVE AMERICAN ⁶ OTHER

FAMILY HISTORY: Do any of your family members suffer from any of the following:

	<u>CHILD</u>	<u>PARENT</u>	<u>GRANDPARENT</u>	<u>AUNT/UNCLE</u>	<u>BROTHER/SISTER</u>
DIABETES, ADULT ONSET	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
DIABETES JUVENILE ONSET	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
HEART DISEASE	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
HEART ATTACK PRIOR TO AGE 50	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
HIGH BLOOD PRESSURE	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
OBESITY/OVERWEIGHT	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
STROKE	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵
ASTHMA	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵

HISTORY:

Medications:

Allergies:

Medical Problems:

HOW MANY HOURS PER DAY DO YOU PARTICIPATE IN?

	<u>LESS THAN 2 Hours</u>	<u>2 Hours</u>	<u>MORE THAN 2 Hours</u>
1. Screen Time (TV, Videogames, Computer):	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
2. How many times per week do you eat fast food/at restaurants?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
3. How many times per week do you eat breakfast?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
4. How many times per week do you participate for 60 minutes or more in a physical activity (walking, biking, running, sports)?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
5. How many times per week do you eat 5 or more fruits and/or vegetables in a day?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
6. How many times per week do you eat junk food? (Cookies, candy, soda, Cheetos ©, Doritos ©, etc...)	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³



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- | | <u>0-2 Times</u> | <u>3-5 Times</u> | <u>6 or more Times</u> |
|--|---|---|--|
| 7. How many times per week do you drink 2-3 8 oz cups milk in a day? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| 8. How many times per week do you eat healthy snacks?
(fruit, vegetables, granola bar, rice cake, etc...) | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| 9. Please indicate type of milk do you drink: | <input type="checkbox"/> ¹ Whole | <input type="checkbox"/> ² 2 % low fat | <input type="checkbox"/> ³ Nonfat |
| | <input type="checkbox"/> ⁴ 1 % low fat | <input type="checkbox"/> ⁵ Soy milk | <input type="checkbox"/> ⁶ None |
| 10. Do you typically eat healthy snacks while watching TV, playing video games or on the computer? | <input type="checkbox"/> ¹ Always | <input type="checkbox"/> ² Sometimes | <input type="checkbox"/> ³ Never |

- | | <u>Very Important</u> | <u>Somewhat Important</u> | <u>Not At All Important</u> |
|---|---------------------------------------|---------------------------------------|---------------------------------------|
| 11. How important is it for you to improve your physical activity? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| 12. How important is it for you to improve your nutritional habits? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |

PARENT QUESTIONNAIRE:

13. Zip Code: _____ 14. Year of birth: _____ 15. Country of Birth, _____ 16. How tall are you? ___ feet ___ inches
17. *Optional:* If born outside of the US, approximately how many years have you lived in the USA? _____
18. Sex: M ¹ F ² Race/Ethnic Group: ¹ Hispanic/Latino ² Caucasian (non-Hispanic) ³ African American
⁴ Asian/Pacific Islander ⁵ Other
19. Do you have health insurance? (*Optional*) ¹ Yes ² No
20. If yes, please select: ¹ Medicaid ² Medicare ³ Private Insurance: _____
21. Do you have a Medical doctor that sees you on a regularly? ¹ Yes ² No
22. When was the last time you saw your doctor? ¹ within the past 6 months ² 6 months-1 year ³ more than 1 year ago
23. What is your current marital status? ¹ Married ² Divorced ³ Single/Never Married ⁴ Widowed ⁵ Other
24. How many children do you have? ¹ None ² 1 child ³ 2-3 children ⁴ 4-5 children ⁵ 6 or more children
25. How many years of education have you received? ¹ Up to 4 years ² Between 5 and 8 years ³ Between 9 and 12 years
⁴ Between 13 and 16 years ⁵ More than 17 years
26. Do you have someone with whom you can confide in or share your feelings? ¹ Yes ² To some extent ³ No
27. Do you have someone who can help you solve problems? ¹ Yes ² To some extent ³ No
28. Do you have a job (besides your work at home)? ¹ No ² Yes
- 29a. If yes, what type of work _____
- 29b. If yes, how many hours per week ¹ less than 40 hours per week ² 40 hours or more per week
29. Where were you born?
¹ Mexico ² Central America ³ South America ⁴ Caribbean ⁵ United States ⁶ Asia/Pacific Islands
⁷ Other _____

30. In general, what language do you read and speak?

- | | |
|--|---|
| <input type="checkbox"/> ¹ Only another language, other than English | <input type="checkbox"/> ² Another language, better than English |
| <input type="checkbox"/> ³ Both Equally <input type="checkbox"/> ⁴ English, better than another language | <input type="checkbox"/> ⁵ Only English |

31. What language do you usually speak at home?

- | | |
|--|---|
| <input type="checkbox"/> ¹ Only another language, other than English | <input type="checkbox"/> ² Another language, better than English |
| <input type="checkbox"/> ³ Both Equally <input type="checkbox"/> ⁴ English, better than another language | <input type="checkbox"/> ⁵ Only English |



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32. In which language do you usually think?

- | | | | |
|----------------------------|---|----------------------------|---------------------------------------|
| <input type="checkbox"/> 1 | Only another language, other than English | <input type="checkbox"/> 2 | Another language, better than English |
| <input type="checkbox"/> 3 | Both Equally | <input type="checkbox"/> 4 | English, better than another language |
| | | <input type="checkbox"/> 5 | Only English |

33. Which language do you usually speak with your friends?

- | | | | |
|----------------------------|---|----------------------------|---------------------------------------|
| <input type="checkbox"/> 1 | Only another language, other than English | <input type="checkbox"/> 2 | Another language, better than English |
| <input type="checkbox"/> 3 | Both Equally | <input type="checkbox"/> 4 | English, better than another language |
| | | <input type="checkbox"/> 5 | Only English |

34. Do you have someone who can help you solve problems? 1 Yes 2 To some extent 3 No

35. Would you say your health at the time is...? 1 Excellent 2 Good 3 Fair 4 Poor

36. How physically active are you during a typical day?

- | | | | |
|----------------------------|---|----------------------------|---|
| <input type="checkbox"/> 1 | Very little, I'm mainly standing or sitting | <input type="checkbox"/> 2 | A little, but I do walk for up to 30 minutes on most days |
| <input type="checkbox"/> 3 | I walk 30 minutes or more on most days | <input type="checkbox"/> 4 | I do exercise, dance or play sports (at least 1-2 times per week) |

37. People die when it is their time, and there is not much that can be done about it.

- | | | | | | | | |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1 | Strongly Agree | <input type="checkbox"/> 2 | Agree | <input type="checkbox"/> 3 | Disagree | <input type="checkbox"/> 4 | Strongly Disagree |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|

38. We must live for the present. Who knows what the future may bring.

- | | | | | | | | |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1 | Strongly Agree | <input type="checkbox"/> 2 | Agree | <input type="checkbox"/> 3 | Disagree | <input type="checkbox"/> 4 | Strongly Disagree |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|

39. It is not always wise to plan too far ahead because many things turn out to be a matter of good and bad fortune anyway

- | | | | | | | | |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1 | Strongly Agree | <input type="checkbox"/> 2 | Agree | <input type="checkbox"/> 3 | Disagree | <input type="checkbox"/> 4 | Strongly Disagree |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|

40. It doesn't do any good to try to change the future because the future is in the hands of God

- | | | | | | | | |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|
| <input type="checkbox"/> 1 | Strongly Agree | <input type="checkbox"/> 2 | Agree | <input type="checkbox"/> 3 | Disagree | <input type="checkbox"/> 4 | Strongly Disagree |
|----------------------------|----------------|----------------------------|-------|----------------------------|----------|----------------------------|-------------------|

Please answer these questions below to help us better understand your health.

PARENT MEDICAL HISTORY (please check either yes or no to the following:)

- | | | |
|---|--|---|
| 41. Did your father or brother have a heart attack before age 55? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 42. Did your mother or sister have a heart attack before age 65? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 43. Do you smoke cigarettes? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 44. Are you 20 pounds or more over your normal weight? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 45. Do you exercise 3 or more times per week? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 46. How much time do you spend exercising per time: | <input type="checkbox"/> 1 Less than 20 minutes per time | <input type="checkbox"/> 2 Between 20- 30 minutes |
| | <input type="checkbox"/> 3 30-45 minutes | <input type="checkbox"/> 4 more than 45 minutes |
| 47. Does your job involve physical labor for more than 60 minutes per day? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 48. Do you have diabetes? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 49. Are you now taking prescription medicine for diabetes? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 50. Have you been told by a doctor that you have heart disease, or have had a heart attack? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 51. Have you had a stroke? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 52. Have you ever been told by a doctor that you have high cholesterol? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 53. Are you now taking prescription medicine for high cholesterol? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 54. Have you ever been told by a doctor that you have high blood pressure? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| 55. Are you now taking prescription medicine for high blood pressure? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |

NAME _____ STUDENT ID# _____ SCHOOL/ID# _____