

Today's Date: _____



Name: _____
DOB: ____/____/____ Sex: M__ F__ T__
MRN: _____ (or place label here)

Pediatric Health Assessment

(Ages 5-11) – FOR PARENT/GUARDIAN

Please answer these questions to help us get to know your child better and together we can plan the best care for your child. It is okay to skip any questions you are not comfortable answering.

GENERAL MEDICAL INFORMATION

In the last year, have there been any changes to your child's health or any hospital visits? YES NO
 If yes, describe: _____

Has your child had an allergic reaction (bad effect) from any of the following?

- No known allergies Medicines/Drugs (please describe) _____
- Latex (rubber gloves) Eggs Peanuts Bee stings Shellfish
- Other (please describe) _____

Is your child taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements)? YES NO

If yes – please list: _____

PHYSICAL AND ORAL HEALTH

- Are there times when your family does not have enough food to eat? YES NO
- Does your child eat 5 servings of fruits and vegetables each day? NO YES
- Does your child have more than 8 oz (1 cup) of juice or soda per day? YES NO
- Does your child eat fast food more than once per week? YES NO
- Does your child exercise (play hard - like running or sports) for more than 30 minutes every day? NO YES
- How many hours per day does your child watch TV, go on the internet/phone or play video games? 0-1 1-2 Greater than 2
- Have you talked to your child about puberty? NO YES
 If no, would you like to talk about it today? _____
- Does your child have trouble with constipation or bedwetting? YES NO
- Does your child brush teeth twice daily and floss once a day? NO YES
- When was the last dentist check-up? _____

SAFETY AND INJURY PREVENTION

- When riding in a car, does your child use a seatbelt or booster seat? NO YES
- Does your child always wear a helmet when riding a bike, skateboard, roller blades, or scooter? NO YES
- Does your child know how to swim? NO YES
- Are there guns in your home or anywhere else your child spends time? YES NO
- Do you have a fire and earthquake emergency plan? NO YES
- Do you teach your child how to be safe on the internet? NO YES

SCHOOL AND FRIENDS

- Do you have any concerns about your child's learning or behavior in school? ... YES NO

18. Does your child have at least one friend? NO YES

19. How much school has your child missed in the last month for any reason?

- None 1-3 days 3 or more days

20. What does your child do after school?

EMOTIONAL WELL BEING

21. Who lives in your child's home?

22. Do you have any worries about your child's mood or behavior?

(example – hyperactive, angry, sad, withdrawn, scared, shy, or irritable) YES NO

23. Does your child have any problems with sleep or nightmares? YES NO

24. Does anyone bully or pick on your child, online or at school?..... YES NO

RISK REDUCTION/CONCERNS

25. Do you talk to your child about the risks of drugs, alcohol, and sexual activity? ...NO YES

26. Do you have any worries about your child's behavior? YES NO

27. Does anyone in your child's house smoke cigarettes? YES NO

28. We know that what is happening in a child's life can affect their health.

Have **you, your child or your family** been affected by any of these in the last year? YES NO

- | | |
|----------------------------------|--|
| -Move, deportation or eviction | -Prison/Jail |
| -Divorce, break-up or separation | -DHS involvement/foster care |
| -Death or violence | -Mental illness (depression, anxiety, bipolar disorder, suicide attempt) |
| -Drug or alcohol abuse | -Racism or discrimination |
| -Threats, abuse, or neglect | |

STRENGTHS

Check off all the items that you think are true for your child.

- Our family helps and supports each other.
- My child likes to read.
- My child works hard in school, sports, or other activities.
- My child feels good about him or herself.
- My child has these healthy behaviors (like exercise, healthy eating): _____
- My child/family is involved in my community (religious, sports, service, family, or neighborhood).
- These things make me proud of my child: _____
- Others: _____

ADDITIONAL CONCERNS

Are there any other questions or concerns you would like to discuss today?

Signature: _____ (Parent/Guardian)

for office use: Provider

Reviewed by: _____ Date: _____