SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition

Is he/ she breast feeding?	Y N
Is he/ she on formula?_____	Y N
Is he/ she on a special diet?	Y N

Elimination

Are his/ her stools normal?	Y N
If no…	
Does he/ she have diarrhea?	Y N
Is he/ she constipated?	Y N
Does he/ she spit-up excessively?	Y N

Behavior/ Sleep

Does he/ she sleep all night?	Y N
Does he/ she wake up in the night?	Y N
Is he/ she good natured?	Y N
Is he/ she fussy?	Y N
Is he/ she colicky?	Y N

Gross Motor

Can he/ she lift their head?	Y N

Fine Motor

Can he/ she grasp with their hand?	Y N
Does he/ she follow you with their eyes?	Y N

Social

Is he/she social?	Y N
Does he/ she cuddle?	Y N
Can he/ she recognize faces?	Y N

Language

Does he/ she cry spontaneously?	Y N
Does he/ she respond to sound?	Y N

Birth History

Were there complications during pregnancy?	Y N
Were there complications during labor & delivery?	Y N
Did your baby have complications?	Y N

Concerns

Are you concerned about your child's…

diet	Y N
sleep	Y N
bowels	Y N
family	Y N
developmental	Y N
other concerns:	

Personal

Does he/ she sleep on their back?	Y N
Does he/ she ride in a rear-facing infant car seat?	Y N
Does he/ she live in a smoke-free home?	Y N
Are you getting enough rest?	Y N
Have you been sad, depressed or crying a lot?	Y N
Do you know Infant CPR?	Y N
Are you and your family current on the Pertussis Vaccine?	Y N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list allergies:

To medications-

Other allergies-

SECTION TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Breast **Formula** (circle one)

Birth Weight _____ **Disch. Weight** _____ **Hep B Y N** _____

Hospital_____ **GA:**_____ **Vaginal/C-Section**

Procedures

CIRC PKU Hep B

1 mo	**Date**	**Time**	**Age**	**Height**	%	**Weight**	**Head Circ**	%	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition

Is he/ she breast feeding?	Y	N
Is he/ she on formula?_____	Y	N
Is he/ she on a special diet?	Y	N

Elimination

Are his/ her stools normal?	Y	N
If no…		
Does he/ she have diarrhea?	Y	N
Is he/ she constipated?	Y	N
Does he/ she spit-up excessively?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N
Does he/ she wake up in the night?	Y	N
Is he/ she good natured?	Y	N
Is he/ she fussy?	Y	N
Is he/ she colicky?	Y	N

Gross Motor

Can he/ she lift their head?	Y	N

Fine Motor

Can he/ she hold an object?	Y	N

Social

Is he/she social?	Y	N
Does he/ she follow you with their eyes?	Y	N
Does he/ she smile responsively?	Y	N

Language

Does he/ she listen to sounds?	Y	N
Does he/ she vocalize?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she sleep on their back?	Y	N
Does he/ she live in a smoke-free home?	Y	N
Will he/ she be attending a daycare?	Y	N
Does he/ she ride in a rear-facing infant car seat?	Y	N
Are you getting enough rest?	Y	N
Have you been sad, depressed or crying a lot?	Y	N
Do you know infant CPR?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N

How would you like to be contacted? (only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Breast **Formula** (circle one)

Procedures

Pentacel Hep B Pneumo 13 RotaTeq

	Date	Time	Age	Height		Weight		Head Circ	Temp	Insurance
2 mo					%		%			

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition

Is he/ she breast feeding?	Y	N
Is he/ she on formula?_____	Y	N
Is he/ she on solids?	Y	N
Is he/ she on a special diet?	Y	N

Elimination

Are his/ her stools normal?	Y	N
If no…		
Does he/ she have diarrhea?	Y	N
Is he/ she constipated?	Y	N
Does he/ she spit-up excessively?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N
Does he/ she wake up in the night?	Y	N
Is he/ she good natured?	Y	N
Is he/ she fussy?	Y	N
Is he/ she colicky?	Y	N

Gross Motor

Can he/ she roll on to their back?	Y	N
Can he/ she hold their head up steady?	Y	N

Fine Motor

Can he/ she hold their hands together?	Y	N
Can he/ she follow you with their eyes well?	Y	N
Can he/ she grasp toys?	Y	N

Social

Is he/she social?	Y	N
Does he/ she smile spontaneously?	Y	N

Language

Does he/ she laugh?	Y	N
Does he/ she squeal?	Y	N
Does he/ she babble?	Y	N

Concerns

Are you concerned about your child's…		
diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N
other concerns:		

Personal

Does he/ she sleep on their back?	Y	N
Does he/ she sleep in a room alone?	Y	N
Does he/ she ride in a rear-facing car seat?	Y	N
Will he/ she be attending a daycare?	Y	N
Does he/ she live in a smoke-free home?	Y	N
Do you have smoke alarms in your house?	Y	N
Any problems with the first immunizations?	Y	N
Have you been sad, depressed or crying a lot?	Y	N
Do you know infant CPR?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Breast Formula (circle one)

Procedures

Pentacel Pneumo 13 RotaTeq

4 mo	**Date**	**Time**	**Age**	**Height**		**Weight**		**Head Circ**	**Temp**	**Insurance**
					%		%			

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition

Is he/ she breast feeding?	Y	N
Is he/ she on formula?_____	Y	N
Is he/ she on solids?	Y	N
Is he/ she on a special diet?	Y	N

Elimination

Are his/ her stools normal?	Y	N
If no…		
Does he/ she have diarrhea?	Y	N
Is he/ she constipated?	Y	N
Does he/ she spit-up excessively?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N
Does he/ she wake up in the night?	Y	N
Is he/ she good natured?	Y	N
Is he/ she fussy?	Y	N
Is he/ she colicky?	Y	N

Gross Motor

Can he/ she roll over?	Y	N
Can he/ she sit with help?	Y	N
Can he/ she hold their head up steady?	Y	N

Fine Motor

Can he/ she grasp toys?	Y	N
Does he/ she transfer objects between hands?	Y	N

Social

Is he/she social?	Y	N
Does he/ she smile at the mirror?	Y	N

Language

Does he/ she coo?	Y	N
Does he/ she laugh?	Y	N
Does he/ she babble?	Y	N
Does he/ she turn to sounds?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she ride in a rear-facing car seat?	Y	N
Is he/ she be attending a daycare?	Y	N
Does he/ she live in a smoke-free home?	Y	N
Do you have smoke alarms in your house?	Y	N
Any problems with the second immunizations?	Y	N
Do you know infant CPR?	Y	N
Does your child…		
live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ?	Y	N
live in or regularly visit a house built before 1978 with recent or ongoing renovation?	Y	N
have a sibling or playmate who now has or did have lead poisoning?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N

How would you like to be contacted? (only choose one)

□ Phone-

□ Text-

□ Email-

Please list all the medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Breast Formula Solids (circle one)

Procedures

Pentacel Hep-B Pneumo 13 RotaTeq Flu

	Date	Time	Age	Height		Weight		Head Circ	Temp	Insurance
6 mo					%		%			

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition

Is he/ she breast feeding?	Y	N
Is he/ she on formula?_____	Y	N
Is he/ she on solids?	Y	N
Is he/ she on a special diet?	Y	N

Elimination

Are his/ her stools normal?	Y	N
If no…		
Does he/ she have diarrhea?	Y	N
Is he/ she constipated?	Y	N
Does he/ she spit-up excessively?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N
Does he/ she wake up in the night?	Y	N
Is he/ she good natured?	Y	N
Is he/ she fussy?	Y	N
Is he/ she colicky?	Y	N

Gross Motor

Can he/ she pull to stand up?	Y	N
Does he/ she scoot along?	Y	N
Can he/ she stand with help?	Y	N

Fine Motor

Can he/ she hold their bottle?	Y	N
Can he/ she feed themselves with their hands?	Y	N
Can he/ she pick up objects with thumb and finger?	Y	N
Can he/ she bang cubes together?	Y	N

Social

Is he/she social?	Y	N
Does he/ she play peek-a-boo?	Y	N

Language

Does he/ she respond to their name?	Y	N
Does he/ she say Mama/Dada?	Y	N
Does he/ she imitate sounds?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she ride in a rear-facing car seat?	Y	N
Is he/ she be attending a daycare?	Y	N
Does he/ she live in a smoke-free home?	Y	N
Do you know infant CPR?	Y	N
Does your child…	Y	N
live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ?	Y	N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)?	Y	N
have a sibling or playmate who now has or did have lead poisoning?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Breast Formula Solids (circle one)

Procedures

Flu HGB_____

9 mo	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**Head Circ**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patients name: **Date:**

Nutrition
Is he/ she breast feeding? Y N
Is he/ she on formula?_____ Y N
Is he/ she on solids? Y N
Is he/ she on a special diet? Y N

Elimination
Are his/ her stools normal? Y N
If no…
Does he/ she have diarrhea? Y N
Is he/ she constipated? Y N
Does he/ she spit-up excessively? Y N

Behavior/ Sleep
Does he/ she sleep all night? Y N
Does he/ she wake up in the night? Y N
Is he/ she good natured? Y N
Is he/ she fussy? Y N
Is he/ she colicky? Y N

Gross Motor
Can he/ she walk by themselves? Y N
Can he/ she walk with assistance? Y N

Fine Motor
Can he/ she throw objects? Y N
Can he/ she pick up objects with thumb and finger? Y N
Can he/ she bang cubes together? Y N

Social
Is he/she social? Y N
Does he/ she come when called? Y N
Does he/ she play pat-a-cake? Y N

Language
Can he/ she follow one step commands? Y N
Does he/ she say 2 words besides Mama/Dada? Y N

Concerns
Are you concerned about your child's…
diet Y N
sleep Y N
bowels Y N
family Y N
developmental Y N
other concerns:

Personal
Does he/ she ride in a rear facing car seat? Y N
Is he/ she be attending a daycare? Y N
Is there a firearm in the home? If yes…… Y N
Is the gun safely locked up with ammunition kept separate from firearm? Y N
Is a Trigger Lock always used? Y N
Does he/ she live in a smoke-free home? Y N
Do you know infant CPR? Y N

Does your child…
live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ? Y N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)? Y N
have a sibling or playmate who now has or did have lead poisoning? Y N
Are you and your family current on the Pertussis Vaccine? Y N

How would you like to be contacted? (only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Breast **Formula** **Solids** (circle one)

Procedures
Prevnar 13 Hep A Varicella Flu HGB_____

12 mo	Date	Time	Age	Height	%	Weight	%	Head Circ	Temp	Insurance

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition

Is he/ she breast feeding?	Y	N
Is he/ she on formula?_____	Y	N
Is he/ she on solids?	Y	N
Is he/ she on a special diet?	Y	N

Elimination

Are his/ her stools normal?	Y	N
If no…		
Does he/ she have diarrhea?	Y	N
Is he/ she constipated?	Y	N
Does he/ she spit-up excessively?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N
Does he/ she wake up in the night?	Y	N
Is he/ she good natured?	Y	N
Is he/ she fussy?	Y	N
Is he/ she colicky?	Y	N

Gross Motor

Can he/ she walk well?	Y	N
Can he/ she climb stairs?	Y	N
Does he/ she fall and get back up?	Y	N

Fine Motor

Can he/ she scribble spontaneously?	Y	N
Can he/ she build a tower with 2 cubes?	Y	N

Social

Is he/she social?	Y	N
Can he/ she play ball?	Y	N

Language

Can he/ she say 3-6 words besides Mama/Dada?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she ride in a rear facing car seat?	Y	N
Is he/ she be attending a daycare?	Y	N
Does he/ she live in a smoke-free home?	Y	N
Is there a firearm in the home? If yes…….	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N
Does your child…		
live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ?	Y	N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)?	Y	N
have a sibling or playmate who now has or did have lead poisoning?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medication patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room:

Breast Formula Solids (circle one)

Procedures

MMR Flu

	Date	Time	Age	Height		Weight		Head Circ	Temp	Insurance
15 mo					%		%			

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Nutrition
Is he/ she breast feeding? Y N
Is he/ she on formula?_____ Y N
Is he/ she on solids? Y N
Is he/ she on a special diet? Y N

Elimination
Are his/ her stools normal? Y N
If no…
Does he/ she have diarrhea? Y N
Is he/ she constipated? Y N
Does he/ she spit-up excessively? Y N

Behavior/ Sleep
Does he/ she sleep all night? Y N
Does he/ she wake up in the night? Y N
Is he/ she good natured? Y N
Is he/ she fussy? Y N
Is he/ she colicky? Y N

Gross Motor
Can he/ she run? Y N
Can he/ she throw overhand? Y N
Can he/ she walk up steps? Y N

Fine Motor
Can he/ she feed themselves with a spoon? Y N
Can he/ she build a 4 cube tower? Y N

Social
Is he/she social? Y N
Can he/ she remove their clothing? Y N
Does he/ she help with simple tasks? Y N
Does he/ she play well with other children? Y N
Does he/ she mimic household chores? Y N

Language
Does he/ she use 7-20 words? Y N
Does he/ she use 2 word phrases? Y N
Does he/ she know their body parts? Y N

Concerns
Are you concerned about your child's…
diet Y N
sleep Y N
bowels Y N
family Y N
developmental Y N
other concerns:

Personal
Does he/ she ride in a rear facing car seat? Y N
Is he/ she be attending a daycare? Y N
Does he/ she live in a smoke-free home? Y N
Is there a firearm in the home? If yes….. Y N
Is the gun safely locked up with ammunition kept separate from firearm? Y N
Is a Trigger lock always used? Y N
Does your child…
live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ? Y N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)? Y N
have a sibling or playmate who now has or did have lead poisoning? Y N
Are you and your family current on the Pertussis Vaccine? Y N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Text-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication:

Other allergies:

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room:

Milk_____%

Procedures
Pentacel Hep A Flu

18 mo	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**Head Circ**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patients name: **Date:**

Nutrition

Does he/ she have a balanced diet?	Y	N
Is he/ she a finicky eater?	Y	N
Does he/ she get enough calcium?	Y	N
Does he/ she brush their teeth?	Y	N

Elimination

Are his/ her stools normal?	Y	N
Is he/ she potty trained?	Y	N
Has he/ se started to potty train?	Y	N
Is he/ she constipated?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N
Does he/ she wake up in the night?	Y	N

Gross Motor

Can he/ she run?	Y	N
Can he/ she jump?	Y	N
Can he/ she throw overhand?	Y	N
Can he/ she walk up steps?	Y	N

Fine Motor

Can he/ she handle a spoon well?	Y	N
Can he/ she build a 4-6 cube tower?	Y	N

Social

Is he/ she social?	Y	N
Can he/ she remove their clothing?	Y	N
Does he/ she help with simple tasks?	Y	N
Does he/ she play well with other children?	Y	N

Language

Does he/ she use 7-20 words?	Y	N
Does he/ she use 2 word phrases?	Y	N
Does he/ she know their body parts?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she ride in a car seat in the back seat?	Y	N
Is he/ she be attending a daycare?	Y	N
Does he/ she live in a smoke-free home?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N

Does your child…

live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ?	Y	N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)?	Y	N
have a sibling or playmate who now has or did have lead poisoning?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room:

Milk_____%

Procedures

HGB_____

	Date	Time	Age	Height		Weight		B/P	Temp	Insurance
2 yrs					%		%	/		

SECTION TO BE COMPLETED BY PARENT

Patients name: **Date:**

Nutrition

Does he/ she have a balanced diet?	Y	N
Is he/ she a finicky eater?	Y	N
Does he/ she get enough calcium?	Y	N
Does he/ she brush their teeth?	Y	N
Has he/ she been to the dentist?	Y	N

Elimination

Are his/ her stools normal?	Y	N
Is he/ she potty trained?	Y	N
Has he/ se started to potty train?	Y	N
Is he/ she constipated?	Y	N

Behavior/ Sleep

Does he/ she sleep all night?	Y	N

Gross Motor

Can he/ she run?	Y	N
Can he/ she jump?	Y	N
Can he/ she throw overhand?	Y	N
Can he/ she walk up steps?	Y	N

Fine Motor

Can he/ she handle a spoon well?	Y	N
Can he/ she build a 4-6 cube tower?	Y	N

Social

Is he/ she social?	Y	N
Can he/ she remove their clothing?	Y	N
Does he/ she help with simple tasks?	Y	N
Does he/ she play well with other children?	Y	N

Language

Does he/ she use 7-20 words?	Y	N
Does he/ she use 2 word phrases?	Y	N
Does he/ she name their body parts?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she ride in a booster seat in the back seat?	Y	N
Is he/ she be attending a daycare?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N

Does your child…

live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ?	Y	N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)?	Y	N
have a sibling or playmate who now has or did have lead poisoning?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N
Does your child live in a smoke free home?	Y	N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

HGB_____

3 yrs	**Date**	**Time**	**Age**	**Height**		**Weight**		**B/P**	**Temp**	**Insurance**
					%		%	/		

SECTION TO BE COMPLETED BY PARENT

Patients name: **Date:**

Nutrition

Does he/ she get enough iron & calcium?	Y	N
Does he/ she have a balanced diet?	Y	N
Are you limiting high-fat & sugar snacks?	Y	N
Does he/ she brush their teeth?	Y	N
Has he/ she been to the dentist?	Y	N

Elimination

Is he/ she constipated?	Y	N
Does he/ she have diarrhea?	Y	N
Does he/ she wet the bed at night?	Y	N
Does he/ she wet themselves in the day?	Y	N

Behavior/ Sleep

Does he/ she mind adults?	Y	N

Gross Motor

Can he/ she hop on one foot?	Y	N
Can he/ she throw?	Y	N
Can he/ she kick?	Y	N
Can he/ she jump?	Y	N

Fine Motor

Can he/ she copy circles or squares?	Y	N
Can he/ she draw a person with extremities?	Y	N

Social

Is he/ she social?	Y	N
Is he/ she involved in sports or hobbies?	Y	N
Does he/ she play well with other children?	Y	N
Can he/ she dress themselves?	Y	N

Language

Can he/ she speak clearly	Y	N
Does he/ she know their colors, letters,& numbers?	Y	N

Concerns

Are you concerned about your child's…

diet	Y	N
sleep	Y	N
bowels	Y	N
family	Y	N
developmental	Y	N

other concerns:

Personal

Does he/ she ride in a booster seat in the back seat?	Y	N
Does he/ she know their full name, address, phone # & 911?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N

Does your child…

live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ?	Y	N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)?	Y	N
have a sibling or playmate who now has or did have lead poisoning?	Y	N
Are you and your family current on the Pertussis Vaccine?	Y	N
Does your child live in a smoke free home?	Y	N

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

HGB_____

4 yrs	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patients name: **Date:**

Nutrition
Does he/ she have balanced meals? Y N
Does he/ she have a good appetite? Y N
Does he/ she brush their teeth? Y N
Has he/ she been to the dentist? Y N

Elimination
Are his/ her stools normal? Y N

School
Does he/ she attend kindergarten? Y N
Does he/ she attend 1st grade? Y N
Is he/ she doing well in school? Y N
Has he/ she had any problems? Y N

Gross Motor
Are his/ her motor skills normal? Y N

Fine Motor
Are his/ her motor skills normal? Y N

Social
Are his/ her social skills normal? Y N
Does she get along well with others? Y N

Language
Are his/ her language skills normal? Y N

Personal
Does your child…
ride in a booster seat in the back seat? Y N
Is there a firearm in the home? If yes…… Y N
Is the gun safely locked up with ammunition kept separate from firearm? Y N
Is a trigger lock always used? Y N
know their full name, address, phone # & 911? Y N
live in or regularly visit a house built before 1950 (daycare, babysitter, or relative) ? Y N
live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the last 6 months)? Y N
have a sibling or playmate who now has or did have lead poisoning? Y N
Are you and your family current on the Pertussis Vaccine? Y N
Does your child live in a Smoke Free home? Y N

Concerns
Are you concerned about your child's…
diet Y N
sleep Y N
bowels Y N
family Y N
developmental Y N

Other concerns:

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures
DTaP IPV Hep A Varicella MMR Flu Urine HGB_____ Vision Rt_____ Lt_____

5-6 yrs	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Childs Name: **Date:**

Personal/Social History

Do you have any concerns about your child's…

overall progress in school	Y	N
happiness, self esteem, self confidence	Y	N
ability to get along with peers and teachers	Y	N
ability to sit still, listen or participate	Y	N
willingness to follow rules at school	Y	N
progress in reading or math	Y	N
school attendance	Y	N
overall health and development	Y	N
irritability, temper outburts, excessive anger	Y	N

Does he/she have adult supervision before and after school?	Y	N
Does he/she exercise on a regular basis?	Y	N
Does he/she use a helmet skating & biking?	Y	N
Does he/she use a booster seat, and ride in back?	Y	N
Do you counsel him/her about avoiding the use of alcohol, tobacco, drugs and inhalants?	Y	N
Is there a firearm in the home? If yes…….	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used	Y	N
Does he/she live in a smoke free home?	Y	N

Review of Systems

Are you concerned about your child's…

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
urinary control, bed wetting, urinary infections	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N
	Y	N

Do you have any other concerns you wish to discuss?

How would you like to be contacted?
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

□ Daily-

□ Occasionally-

□ Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

7-9 yrs	**Date**	**Time**	**Age**	**Height**		**Weight**		**B/P**	**Temp**	**Insurance**
					%		%			

SECTION TO BE COMPLETED BY PARENT

Patients Name: **Date:**

Personal/Social History

Do you have concerns about your child's….

overall progress in school	Y	N
happiness, self esteem, self confidence	Y	N
ability to sit still, listen or participate	Y	N
school attendance	Y	N
overall health and physical development	Y	N
social development (lack of friends, withdrawal from family)	Y	N
behavioral development (temper outbursts, excessive shyness, aggression, violence)	Y	N
emotional development (mood changes, anxiety, depression)	Y	N

Does he exercise on a regular basis?	Y	N
Does he use a helmet for skating or biking?	Y	N
Does he use a seat belt when riding in a car?	Y	N
Do you counsel him about avoiding the use of alcohol, tobacco, drugs and inhalants?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N
Does he live in a smoke free home?	Y	N

Review of Systems

Are you concerned about your child's…

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
kidney or bladder problems, infections, blood in urine	Y	N
joint pain, stiffness, swelling; muscle pain, weakness	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N

Do you have any other concerns you wish to discuss?

How would you like to be contacted:
(only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medication-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

Adacel Varicella Menactra Gardasil Hep A Flu Urine HGB_____ Vision Rt_____ Lt_____

10-12 **male**	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Child's Name: **Date:**

Personal/ Social History

Do you have concerns about your child's...

overall progress in school	Y	N
happiness, self esteem/ confidence	Y	N
ability to sit still, listen or participate	Y	N
school attendance	Y	N
overall health	Y	N
physical development	Y	N
has menstruation begun?	Y	N
social development (lack of friends, excessive shyness, withdrawal from family)	Y	N
behavioral development (temper outbursts, aggression, violence	Y	N
emotional development (mood changes, anxiety, depression)	Y	N

Does she exercise on a regular basis?	Y	N
Does she use a helmet for skating or biking?	Y	N
Does she use a seat belt when riding in a car?	Y	N
Do you counsel her about avoiding the use of alcohol, tobacco, drugs and inhalants?	Y	N
Is there a firearm in the home? If yes…..	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N
Does she live in a smoke free home?	Y	N

Review of Systems

Are you concerned about your child's…

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
kidney or bladder problems, infections, blood in urine	Y	N
joint pain, stiffness, swelling; muscle pain, weakness	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N

Do you have any other concerns you wish to discuss?	Y	N

How would you like to be contacted? (only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

□Daily-

□ Occasionally-

□ Over the counter-

Please list all allergies:

□ To medications-

□ Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

Adacel Menactra Hep A Gardasil Varicella MMR Flu Urine HGB_____ Vision Rt_____ Lt_____

10-12 **female**	**Date**	**Time**	**Age**	**Height**	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patients name: **Date:**

Personal/ Social History

Do you have concerns about your child's...

overall progress in school	Y	N
happiness, self esteem/ confidence	Y	N
ability to sit still, listen or participate	Y	N
school attendance	Y	N
overall health	Y	N
physical development	Y	N
Has menstruation begun?	Y	N
social development (lack of friends, bad peer influence, withdrawal from family)	Y	N
behavioral development (acting out, temper outbursts, aggression, violence)	Y	N
emotional development (mood changes, anxiety, depression)	Y	N
early sexual activity or inappropriate sexual behavior	Y	N
Does she exercise on a regular basis?	Y	N
Does she use a seat belt when riding in a car?	Y	N
Do you counsel her about avoiding the use of alcohol, tobacco, drugs and inhalants?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N
Does she live in a smoke free home?	Y	N

Review of Systems

Are you concerned about your child's…

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
kidney or bladder problems, infections, blood in urine	Y	N
joint pain, stiffness, swelling; muscle pain, weakness	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N

Do you have any other concerns you wish to discuss?

How would you like to be contacted? (only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

Adacel Menactra Hep A Gardasil Varicella MMR Flu Urine HGB_____ Vision Rt_____ Lt_____

13-15 female	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patient's name: **Date:**

Personal/ Social History

Do you have concerns about your child's…

overall progress in school	Y	N
happiness, self esteem/ confidence	Y	N
ability to sit still, listen or participate	Y	N
school attendance	Y	N
overall health	Y	N
physical development	Y	N
social development (lack of friends, excessive shyness, withdrawal from family)	Y	N
behavioral development (acting out, temper outbursts, aggression, violence)	Y	N
emotional development (mood changes, anxiety, depression)	Y	N
early sexual activity or inappropriate sexual behavior	Y	N

Does he exercise on a regular basis?	Y	N
Does he use a helmet for skating or biking?	Y	N
Does he use a seat belt when riding in a car?	Y	N
Do you counsel him about avoiding the use of alcohol, tobacco, drugs and inhalants?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N
Does he live in a smoke free home?	Y	N

Review of Systems

Are you concerned about your child's…

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
kidney or bladder problems, infections, blood in urine	Y	N
joint pain, stiffness, swelling; muscle pain, weakness	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N

Do you have any other concerns you wish to discuss?

How would you like to be contacted?
(Only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

13-15 male	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Patient's name: **Date:**

Personal/ Social History

Do you have concerns about...

school/work: grades, motivation, concentration, completing assignments	Y	N
overall health	Y	N
lesions, sores or drainage from penis; swelling, tenderness or pain in groin, scrotum or testicles	Y	N
sexual issues: sexual orientation, sex. transmitted diseases, AIDS/HIV, other	Y	N

Are you sexually active now?	Y	N
If yes, do you always use a condom?	Y	N
Do you use cigarettes, smokeless tobacco?	Y	N
Do you drink alcohol? If yes, do you drink:	Y	N
___ beer ___ wine ___ liquor		
___ rarely ___ weekly ___ daily # of drinks _____		
Have you been drunk in the past month?	Y	N
Do you ever drive a vehicle when drinking?	Y	N
Do you ever use recreational drugs?	Y	N
Do you always use a seat belt when in a car?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is a Trigger lock always used?	Y	N
Do you live in a smoke free home?	Y	N

Review of Systems

Are you concerned about...

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
kidney or bladder problems, infections, blood in urine	Y	N
joint pain, stiffness, swelling; muscle pain, weakness	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N

Do you have any other concerns you wish to discuss?

How would you like to be contacted?
(Only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

Other allergies-

SECTION TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Procedures

Adacel Varicella Menactra Gardasil Hep A Flu Urine HGB_____ Vision Rt_____ Lt_____

16-18 male	**Date**	**Time**	**Age**	**Height**		**Weight**		**B/P**	**Temp**	**Insurance**
					%		%			

SECTION TO BE COMPLETED BY PARENT

Child's Name: **Date:**

Personal/ Social History

Do you have concerns about…

school/work: grades, motivation, concentration, completing assignments	Y	N
overall health	Y	N
your breasts, menses, pelvic pain, vaginal discharge	Y	N
sexual issues: pain or bleeding with intercourse, birth control, pregnancy, sex. transmitted diseases, AIDS/HIV	Y	N
Have you had a pelvic examination?	Y	N
approx. date_____ Pap test _____		
Are you sexually active now?	Y	N
If yes, is a condom always used?	Y	N
Have you ever been sexually mistreated?	Y	N
Do you use cigarettes, smokeless tobacco?	Y	N
Do you drink alcohol? If yes, do you drink:	Y	N
___ beer ___ wine ___ liquor		
___ rarely ___ weekly ___daily # of drinks _____		
Have you been drunk in the past month?	Y	N
Do you ever drive a vehicle when drinking?	Y	N
Do you ever use recreational drugs?	Y	N
Do you always use a seat belt when in a car?	Y	N
Is there a firearm in the home? If yes……	Y	N
Is the gun safely locked up with ammunition kept separate from firearm?	Y	N
Is the Trigger lock always used?	Y	N
Do you live in a smoke free home?	Y	N

Review of Systems

Are you concerned about...

eating habits, weight loss, low energy, sleep habits	Y	N
redness, excessive tearing or discharge from eyes	Y	N
recurrent ear, sinus or throat infections; nosebleeds	Y	N
chest pain, shortness of breath, or irregular heart beat	Y	N
frequent colds, cough, wheezing, recurrent bronchitis	Y	N
abdominal pain, vomiting, diarrhea, constipation	Y	N
kidney or bladder problems, infections, blood in urine	Y	N
joint pain, stiffness, swelling; muscle pain, weakness	Y	N
birthmarks, skin rashes, itching, nail or hair problems	Y	N
recurrent headaches, dizziness, tics, weakness, seizures	Y	N
mood changes, sadness, nervous problems	Y	N
excessive thirst or hunger, increased urination, weight loss	Y	N
paleness, anemia, easy bruising, swollen glands	Y	N
milk, food or drug allergies, recurrent infections	Y	N

Do you have any other concerns you wish to discuss?

How would you like to be contacted? (only choose one)

□ Phone-

□ Text-

□ Email-

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list all allergies:

To medications-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room:

Procedures

Adacel Varicella Menactra Gardasil Hep A Flu Urine HGB_____ Vision Rt_____ Lt_____

16-18 **female**	**Date**	**Time**	**Age**	**Height**	%	**Weight**	%	**B/P**	**Temp**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Child's Name: **Todays Date:**

Reason for today's visit _____

__Fussy
__Up at night
__Fever_____How high_____How long
__Earache
__Sore throat
__Headache
__Red eyes
__Eye drainage
__Vision problems
__Cough

__Congestion
__Nasal discharge__clear_____color____How long
__Wheezing
__Asthma symptoms
__Vomiting
__Nausea
__Stomach pain_____How long
__Colic
__Back pain
__Diarrhea

__Constipation
__Not eating well
__Urinary pain_____frequency
__Muscle or joint pain
__Rash
__Allergy symptoms
__Developmental problems
__Behavior problems

Other Concerns:

Does anyone in the home smoke? Y / N Does patient smoke? Y / N

Preferred Pharmacy_____
***Where should we send your prescriptions?**

How would you like to be contacted?
(only choose one)

□ Phone:

□ Text:

□ Email:

Please list all medications patient takes:

Daily-

Occasionally-

Over the counter-

Please list allergies:

To medications-

Other allergies-

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room

Oxygen Sat'n_____ **Resp**_____ **Pulse**_____

Procedures

S **Sick**	**Date**	**Time**	**Age**	**Height**		**Weight**		**B/P**	**Temp**	**Insurance**
					%		%	/		

Nombre Fecha de nacamiento

SECTION TO BE COMPLETED BY PARENT

Razon de esta visita_____

_____

_____

__Inquieto
__No duerme
__Fiebre_____cuanto_____por cuanto tiempo
__Le duele los oidos
__Le duele los garganta
__Dolor de la cabeza
__Ojos rojos o inflamados
__Mocos en los ojos
__Problemas con la vista
__Tos

__Congestion
__Mocos en la nariz
__Problemas respiratorios
__Asma
__Vomita
__Nausia
__Dolor del estamogo_____cuanto tiempo
__Colicos
__Dolor de la espalda
__Diarea

__Estrenido
__No come
__Le duele cuando orina
__Dolor de los musculos o los hueso
__Manchitas o granitos
__Alergias
__Problemas de desarrollo
__Problemas de comportamiento

Otros problemas hoy?

Alguien en su casa fuma ? S / N Fuma el paciente? S / N

Medicaciones que esta tomando_____ Alergia a medicaciones_____

TO BE COMPLETED BY DOCTOR/NURSE

Name DOB / / Seen with: Mth Fth Other Rm

Oxygen Sat'n_____ **Resp**_____ **Pulse**_____

Current Meds:

Drug Allergies: Y N

G	Nk	Ext
Ey	L	Nr
E	H	S
N	A	
M	G/R	

Other Diagnosis: New Pt. WCC Level_____

Procedures

S Sick	**Date**	**Time**	**Age**	**Height**	**Weight**	**B/P**	**Temp**	**Insurance**
				%	%	/		

Name **DOB / /** **Seen with: Mth Fth Other** **Rm**

Drug Allergies: Y N

Medications:

Procedures

FLU Rocephin Gardasil New Pt. WCC Level_____

N Nurse Visit	**Date**	**Time**	**Age**	**Weight**	**Insurance**

Name **DOB / /** **Seen with: Mth Fth Other** **Rm**

Drug Allergies: Y N

Medications:

Procedures

FLU Rocephin Gardasil New Pt. WCC Level_____

N Nurse Visit	**Date**	**Time**	**Age**	**Weight**	**Insurance**

SECTION TO BE COMPLETED BY PARENT

Child's Name: **Todays Date:**

Please rate the following on a scale of 0-3 (not true to very true)

Restless or overactive	0	1	2	3
Excitable or impulsive	0	1	2	3
Fails to finish things he/ she starts	0	1	2	3
Inattentive or easily distracted	0	1	2	3
Temper outbursts	0	1	2	3
Fidgeting	0	1	2	3
Disturbs other children	0	1	2	3
Demands must be met immediately-easily frustrated	0	1	2	3
Cries often and easily	0	1	2	3
Mood changes quickly and drastically	0	1	2	3

Please rate the following:

Appetite	Good	Fair	Poor	Improved
Sleep	Good	Fair	Poor	Improved
GI upset	Good	Fair	Poor	Improved
Headache	Good	Fair	Poor	Improved
Tremors	Good	Fair	Poor	Improved
Rebound	Good	Fair	Poor	Improved
Mood	Good	Fair	Poor	Improved
Compliance	Good	Fair	Poor	Improved
Duration of efficacy	Good	Fair	Poor	Improved

Please rate the following on a scale 1-5 (poor to excellent)

Attention at school	1	2	3	4	5
Attention at home	1	2	3	4	5
Hyperactivity	1	2	3	4	5
Impulsivity	1	2	3	4	5
Forgetfulness	1	2	3	4	5
Distractibility	1	2	3	4	5
Organization	1	2	3	4	5
Home assessment	1	2	3	4	5
School behavior	1	2	3	4	5
After school activities	1	2	3	4	5
Social interactions	1	2	3	4	5
Family participation	1	2	3	4	5
Disruptive behaviors	1	2	3	4	5
Accidents/ Injuries	1	2	3	4	5

Other Concerns/ Comments:

How would you like to be contacted?

□ Email-

□ Text-

□ Phone-

□ Mail-

Please list all medications patient takes:

Daily-

Occasionaly-

Over the counter-

Please list all allergies:

To medications:

Other allergies:

TO BE COMPLETED BY DOCTOR/NURSE

Name: DOB / / Seen with: Mth Fth Other Room:

Previous Meds:

GDS	S	T
1		
2		
3		
4		
5		
6		
7		
8		
9		
0		

Procedures

B Behavior	Date	Time	Age	Height		Weight		B/P	Temp	Insurance
					%		%			

Name **DOB / /** **Seen with: Mth Fth Other** **Rm**

Time of Injury:

Location of Injury:

How it happened:

Medications:

Drug Allergies: Y N

Procedures

New Pt. WCC Level_____

Injury	Date	Time	Age	Weight	Insurance

Name **DOB / /** **Seen with: Mth Fth Other** **Rm**

Time of Injury:

Location of Injury:

How it happened:

Medications:

Drug Allergies: Y N

Procedures

New Pt. WCC Level_____

Injury	Date	Time	Age	Weight	Insurance