PEDIATRIC HEALTH
ASSESSMENT FORM
6 TO 10 YEARS

CHILD'S NAME:_____ AGE:_____ DATE:_____

ALL MEDICATIONS:_____ALLERGIES:_____

ALL MEDICAL PROBLEMS?_____

_____

PRESENT CONCERNS/PROBLEMS:_____

_____

ACCOMPANIED BY:_____ RELATIONSHIP:_____

DAILY LIVING: **(FILLED OUT BY PARENT OR GUARDIAN)**

DIET: circle which type MILK- whole, 2%, 1%, SKIM (HOW MANY GLASSES OR OUNCES/DAY)_____

DAIRY OTHER THAN MILK (Like yogurt) servings per day_____

MEALS (SERVINGS/DAY) CEREAL/BREAD/GRAIN_____ FRUIT_____ VEGS_____ MEAT/PROTEIN_____

JUICES(CUPS/DAY)_____ WHAT OTHER DRINKS_____CUPS/DAY_____

SNACKS(TIMES/DAY)_____ EXAMPLES OF SNACKS_____

Circle which ones VITAMINS/FLUORIDE/IRON …….. ☐ NO ☐ YES

ANY ACCESS TO WEAPONS?……. ☐ NO ☐ YES
ANY SIBLING RIVALRY?……... ☐ NO ☐ YES
ANY STRESSFUL SITUATIONS IN THE HOUSEHOLD? describe briefly below…….. ☐ NO ☐ YES
_____
DO PARENTS OR CAREGIVERS EVER SMOKE?…… ☐ NO ☐ YES
ANY EXPOSURE TO ANYONE WITH TB OR WITH HIGH RISK (BORN OR LIVED OUTSIDE THE UNITED STATES, HOMELESS, INCARCERATED, HIV/DRUG USE)? …… ☐ NO ☐ YES
ANY RELATIVES WITH HEART DISEASE OR HIGH CHOLESTEROL BEFORE AGE 55? ☐ NO ☐ YES
IS BOOSTER SEAT OR SEAT BELT USED ALL THE TIME?…… ☐ NO ☐ YES
HAVE SMOKE ALARMS?…….. ☐ NO ☐ YES
HOUSE BEING RENOVATED OR BUILT BEFORE 1980?..... ☐ NO ☐ YES

TOILET HABITS (DRY AT NIGHT? (NO/YES) SOILS PANTS OR ACCIDENTS DURING DAY? (NO/ YES)
CONSTIPATION OR HARD STOOLS? (NO/YES) HAS A BOWEL MOVEMENT EVERYDAY? (NO/YES)

ANY CONCERNS ABOUT VISION OR HEARING? _____

DESCRIBE ANY PERSONALITY OR BEHAVIOR PROBLEMS:_____

DESCRIBE DAY CARE/ AFTER SCHOOL ACTIVITIES:_____

WHAT SPORTS DOES YOUR CHILD PLAY?_____

HOURS OF EXERCISE OR PHYSCIAL ACTIVITY PER DAY?_____

HAS HOUSEHOLD CHORES? Y/N IF YES WHAT?_____ HAVE ALLOWANCES? Y/N

HOURS OF TV, VIDEO OR COMPUTER PER DAY?_____

HOW MANY FRIENDS DOES YOUR CHILD HAVE?_____

WHEN WAS THE LAST DENTAL EXAM?_____

SLEEPS IN OWN BED……..Y/N. HOURS OF SLEEP AT NIGHT_____

SCHOOL: WHAT GRADE IS CHILD IN? _____ WHAT GRADES DOES CHILD GET IN SCHOOL?_____

ANY PROBLEMS AT SCHOOL? YES/NO IF YES DESCRIBE_____

TIME SPENT PER DAY ON HOMEWORK AND READING AT HOME? (HOURS/DAY)_____

WHO LIVES AT HOME?_____