HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

					Parent	or guardia	n			Date
ame:							Male/Female:			
Address:	ress:				City					
					Zip:					
Parent/Guardian:					Phor	e/Work:		 Но	me:	
Parent/Guardian:										
Number in household: _					Туре	of famil	y housing:			
hysician:	, ,				Type of family housing: Date of last examination:					
Dentist:					Date of last examination:					
Eye Doctor:					Date of last examination:					
School:					Com	munity S	ervices:			
FAMILY HEALTH HIST						.*				
Response Codes: M		nal	P = Pa	aternal	S = Sibling $NA = Not applicable.$					
•						·	5	Code		Comment
cancer, convulsions, n. Does any family member Comment? CHILD/ADOLESCENT I Response Codes: Birth weight Did this child walk, tal. Does this child/adoles a. See a health care prob. Use any medication c. Have a history of a d. Have a history of a e. Have a history of of f. Age of menarche g. Have a history of vih. Have a problem wit i. Have any emotional j. Need any special he k. Have sexuality cond. Have any chronic ill	HISTOR = Yes Were lk, and d scent: ovider ro n, drugs, ny hospi ny child ther com ision, sp th being or beha elp in sch cerns?	there any levelop at egularly? or alcoholatization lhood dishmunicab Havech, heatired or ovioral propool or da	N = No y pre-natal the usual ol? ns, surgeric eases/illne ole disease: e a history nring or converactive? obtems? ny care?	or delivitime? es or emesses? s? of men	NA = N ery prob ergency strual preation pro	ot application of app	nity? - ible. - its?	Code		Comment
Headache								Bac	k/spine/extre	mity problems
Cold/sore throat			ever		lia Oral/dental					
					tive	ive Urinary/bowel O				
st present concerns of cl	nild/pare	ent/guard	ian:							
nmunization: Record dat						T		T		
	1 st	2 nd	3rd	4 th	5 th	6 th		1st	2 nd	3rd
DPT							MMR			
Td/DT							НВУ	,		
			 				110 A			
OPV or IPV										
HIB										

Pulse:	Sickl	d Pressure:	Hgb or Lead Other	Het:		
Code each item as follo 0 = No significant findin 1 = significant findings			Description of Find	ings		
General appearance						
Integument						
Head - neck						
EENT			We do not be a second of the s			
Oral - dental						
Thorax						
Breasts						
Cardiovascular						
Abdomen		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		NATIONAL ACTION AND THE ACTION AND ACTION ASSESSMENT OF THE ACTION ASSESSMENT ASSESSMENT OF THE ACTION ASSESSMENT OF THE ACTION ASSESSMENT OF THE ACTION ASSESSMENT OF THE ACTION ASSESSMENT A		
Musculoskeletal						
Genitourinary		4-9-1				
Neurological						
Enrolled in WIC Food intake review. I milk/milk products (b fruit/vegetables Meat, beans, eggs breads, cereals 2. Development: 3. Speech:	Receiving vitar Results: oreast fed/type of formula Type of screen Type of screen	nin supplement with iro) Results: Results:	on [] Without iron			
4. Hearing:5. Vision:	Type of screen	Results:		Date last screen:		
Significant assessment f		icsuits	1	e (circle those discussed) 8. Lifestyle		
Recommendations (inclu	de referrals):		Nutrition Parenting Family planning	9. Development 10. Behavior 11. Sexuality		
Follow Up:			5. Discipline 6. Immunizations 7. Hygiene Comments:	12. Dental 13. Other		
Additional information n	nay be attached		1			
	Date	Signature of physic	ysician or nurse approved to perform health assessments			

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.