Child's name_______________________________ Date of birth _____________ Today's Date __________
(first last)

Screening for Child Age 11 and older

Age _____ years

Nutrition	How many ounces of milk per day	None 4 8 16 24 >25
	What type of milk	Whole 2% 1% Skim Soy Rice Other
	How many ounces of juice per day	None 4 8 16 24 >25
	How many ounces of water per day	None 4 8 16 24 >25
	How many caffeinated drinks per day	None 1 2 3 4 5
	Eats regular meals including fruits/vegetable	Yes No
	Protein source	Red meat Chicken Turkey Fish

Education	School grade	5th 6th 7th 8th 9th 10th 11th 12th other
	Special Education	No Yes
	School Performance	A B C D F other
	Parent/teacher concerns	No Yes
	Behavior/Attention concerns	No Yes
	Attention	Normal Abnormal
	Homework	Normal Abnormal
	Social Interaction	Normal Abnormal

Behavior	Sleeping Concerns	No Yes
	Has ways to cope with stress	Yes No
	Gets depressed/anxious Irritable/mood swings	No Yes
	Has family members to turn to for help	Yes No
	Has concerns about body appearance	No Yes
	Has friends	Yes No
	Uses tobacco/alcohol/drugs	No Yes
	At least 1 hour of physical activity per day	Yes No
	Less than 2 hours screen time per day	Yes No
	Does your child wear a helmet with riding a bicycle, skateboard, etc	Yes No
	Car Safety	Back Seat Front Seat
	Uses car seat belt	Yes No
	Brushes teeth	Twice/day Once/day

Has your child been diagnosed with Asthma?	No Yes
When was your child last Influenza Vaccine?	Date:

Date: ______________________________

Patient Name: ____ **DOB** _______________

HISTORY FORM

Is there any __family history__ of:

		NO	YES
1.	Sudden death from heart disease before age 50?	☐	☐
2.	Disability from heart disease before age 50?	☐	☐
3.	Long Q-T Syndrome, Cardiomyopathy, or Marfan syndrome?	☐	☐
4.	High Blood Pressure? Who? ☐ father ☐ mother ☐ grandparent	☐	☐
5.	High Cholesterol? Who? ☐ father ☐ mother ☐ grandparent	☐	☐
6.	Diabetes? Who? ☐ father ☐ mother ☐ grandparent	☐	☐

Is there a __patient history__ of:

		NO	YES
1.	Chest pain with exercise?	☐	☐
2	Excessive fatigue or shortness of breath with exercise?	☐	☐
3.	Fainting?	☐	☐
4.	Heart murmur?	☐	☐
5.	High blood pressure?	☐	☐

Please explain "YES" answers here:

____

____

Who lives in the home with the patient:

____

TURN OVER

TO BE ANSWERED BY PATIENT:

In the past two weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly ever day

2. Feeling down, depressed, hopeless?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly ever day

Have you ever been concerned about someone in your family who is drinking alcohol or using drugs?
☐ Yes ☐ No

Are you exposed to tobacco smoke or chewing tobacco?
☐ Yes ☐ No

Do you live with anyone who uses tobacco?
☐ Yes ☐ No

Are any of your friends using tobacco or e-cigarettes?
☐ Yes ☐ No