

Name: _____

DOB: _____

OR LABEL

CHILD/ADOLESCENT HEALTH ASSESSMENT

Behavioral Health Services
Agnesian HealthCare

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(ORDER FROM PRINTING)

PRIMARY CARE PROVIDER:

YES NO

- Does your child regularly see a primary care provider?
Who is their primary care provider? _____
Where are they located? _____
- Has your child had a physical in the last year? (*over a year refer to PCP*)? When? _____
- Are all of your child's immunizations up to date/completed?
- Has your child had any medical hospitalizations in the last year? If yes, please list: _____

- Does your child have any allergies? If yes, please list: _____

MEDICATIONS: (include supplements, vitamins, or any over-the-counter medications):

Medication	Dose	Date your child started medication	Reason for taking the medication	Medication prescribed by



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SLEEP:

How many hours of sleep does your child get a night? _____

YES NO If you answer yes, give the reason for the sleep problem if known (mind races/caffeine use etc.) If your child has nightmares, can you recall about what?

Does your child have problems falling asleep? _____

Does your child have nightmares? _____

Does your child wake often during the night? _____

Does your child feel rested when they wake up? _____

Does your child wake up early? _____

Is your child difficult to wake? _____

Does your child take any sleep medications? _____

Where does your child sleep? _____

Does your child have a regular bedtime? What time? _____

Does your child have a bedtime routine? _____

Any other sleep issues? _____

NUTRITION:

How many meals does your child eat per day? _____

How much caffeine does your child drink per day? _____

How many energy drinks does your child drink per day? _____

Beliefs/attitude about food

YES NO How much and reason why (stress, diet, etc.)

Has your child gained weight in the past year? _____

Has your child lost any weight in the past year? _____

Are there any foods your child fears (due to calories/fat etc.)? _____

Are there any foods your child won't eat (don't like/allergies to etc.)? _____



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Behaviors around food

YES	NO	PAST	PRESENT	Comments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child purge? (force themselves to vomit)? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child overeat? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child restrict their food intake? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take laxatives or diet pills? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child have negative thoughts about their body or looks? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child hoard food? _____

PHYSICAL ACTIVITY:

YES NO

Does your child currently engage in physical activity that raises their heart rate?
Type of physical activity your child engages in? _____

How often per week does your child engage in physical activity? 1-2 days 3-4 days 5-6 days 7 days

How long are the physical activity sessions? 0-15 min. 15-30 min. 30-45 min. 45-60 + min.

Is your child involved in organized sports? Is so, list: _____

SMOKING:

YES NO

To your knowledge, does your child use tobacco products? If yes, type: _____

To your knowledge, has your child tried to quit? If yes, how many times? _____

Would you or your child like resources on how to quit smoking? Declined

CURRENT/PAST SUBSTANCE USE/ABUSE: *If not applicable, check here:*

Substance	Currently Using	Past Use	How often does your child use?	Date of last known use
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
IV drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		



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FIREARMS:

YES NO

- Are there firearms in the home/apartment?
- Are they locked in a cabinet?
- Is the gun locked?
- If locked, does your child know where the key is/combination is?

PREGNANCY:

- Was the pregnancy with your child planned?
- Did mother receive prenatal care?
If yes, what month did it start? _____
If yes, how often did she go? _____
- Were there any medical complications with the pregnancy? If yes, describe: _____

- Did mother take any medications? If yes, describe: _____

- Did mother drink alcohol?
If yes, how often? daily weekly monthly
If yes, how long did she drink? until found out pregnant throughout
If yes, what types of alcoholic beverages? _____
- Did mother use street drugs?
If yes, what kind? Cannabis crack/cocaine heroin amphetamines other
If yes, how often? daily weekly monthly
If yes, how long? until found out pregnant throughout
- Did mother smoke?
If yes, how much? < 1 cigarette/day < ½ - 1 pack/day > 1 pack/day
If yes, how long did she smoke? until found out pregnant throughout
- Do you currently smoke?
If yes, how much? < 1 cigarette/day < ½ - 1 pack/day > 1 pack/day
- Did any other household members smoke while mother was pregnant?
If yes, how much? < 1 cigarette/day < ½ - 1 pack/day > 1 pack/day



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LABOR and DELIVERY:

YES NO

Was the pregnancy: full term premature

If premature, how many weeks early? _____

Were there delivery complications?

If yes, describe the complication(s): _____

What was his/her birth weight? _____ lbs. _____ oz.

What was his/her APGAR scores if known? 1 min. score _____ 5 min. score _____

POSTPARTUM:

Were there any medical complications after delivery?

If yes, describe complication(s): _____

Did the baby spend any time in ICU?

If yes, how long was the baby in ICU? _____ days

FIRST YEAR OF LIFE:

Did he/she have any sleeping problems in the first year?

Did he/she have any feeding problems in the first year?

Did he/she like being held in the first year?

Did he/she cry a lot in the first year?

When he/she cried, was he/she easy to calm down?

Did he/she seem pretty active?

Compared to other babies, was he/she difficult or hard to care for?

DEVELOPMENTAL MILESTONES:

When did he/she begin to crawl? _____ months (normal = 7-10 months)

When did he/she begin to walk? _____ months (normal = 12-18 months)

When did he/she begin to use single words? _____ months (normal = 18-24 months)

When did he/she begin to talk in sentences? _____ months (normal = 24-36 months)



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PAST/CURRENT MEDICAL HEALTH ISSUES:

Has your child been been treated for or experienced:

YES NO If you answer yes, explain where/how often your child experiences the condition/length of the illness/are they currently being treated for the pain and by whom.

- Does your child have muscle tension? _____
- Does your child have headaches? _____
- Does your child have migraines? _____
- Has your child had a traumatic head injury (if yes-open or closed)? _____
- Epilepsy or seizure disorder? _____
- Heart or lung disease? _____
- Hypoglycemia (low blood sugar)? _____
- Diabetes? _____
- Hypertension (high blood pressure)? _____
- Thyroid issues? _____
- Cancer? _____
- Arthritis? _____
- Has your child had multiple episodes of strep throat? _____
- Recurrent ear infections? _____
- Ever had a broken bone? _____
- Is your child frequently in pain? _____
- Is your child seeing anyone for their pain? _____
- Has your child ever tested positive for TB? _____
- Has your child ever been treated for TB? _____
- Is your child toilet trained? Age toilet trained? _____
- Does your child have daytime urine accidents? _____
- Does your child have nighttime urine accidents? _____
- Does your child have constipation? _____
- Does your child have bowel movement accidents? _____
- Any other medical problems? _____

FEMALES ONLY

- Any current concerns about your daughter's menstrual cycle? Age at start of menses: _____
- Does your daughter have a regular menstrual cycle? _____



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