Name: ______________________________

DOB: ______________________________

OR LABEL

CHILD/ADOLESCENT HEALTH ASSESSMENT

Behavioral Health Services
Agnesian HealthCare

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
❑	❑	❑	❑	Does your child purge? (force themselves to vomit)? ____
❑	❑	❑	❑	Does your child overeat? ____
❑	❑	❑	❑	Does your child restrict their food intake? ____
❑	❑	❑	❑	Does your child take laxatives or diet pills? ____
❑	❑	❑	❑	Does your child have negative thoughts about their body or looks? ____
❑	❑	❑	❑	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 physicial 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 your 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	❑ Yes ❑ No	❑ Yes ❑ No		
Cocaine	❑ Yes ❑ No	❑ Yes ❑ No		
Heroin	❑ Yes ❑ No	❑ Yes ❑ No		
Marijuana	❑ Yes ❑ No	❑ Yes ❑ No		
Pills	❑ Yes ❑ No	❑ Yes ❑ No		
IV drug use	❑ Yes ❑ No	❑ Yes ❑ 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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RISK FACTORS FOR INFECTIOUS DISEASE:

Has your child been treated for or experienced:

YES	NO	
❑	❑	Has your child had/having unprotected sex with multiple partners? ______________
❑	❑	Has your child been treated for a STD ______________
❑	❑	Has your child ever tested positive for HIV? ______________
❑	❑	Is your child currently pregnant? ______________
❑	❑	Has your child ever had a miscarriage? ______________
❑	❑	Has your child ever had an abortion? ______________
❑	❑	Has your child ever had a blood transfusion? ______________

PLEASE CIRCLE THE NUMBER THAT BEST MATCHES YOUR RESPONSE:

Rate your child's current physical health:

1	2	3	4	5	6	7	8	9	10
Poor									Excellent

Is your child's physical health impairing their current ability to function?

1	2	3	4	5	6	7	8	9	10
Not at all									Severely

Rate your child's current mental health:

1	2	3	4	5	6	7	8	9	10
Poor									Excellent

Is your child's mental health impairing their current ability to function?

1	2	3	4	5	6	7	8	9	10
Not at all									Severely

COMPLETED BY:

____
SIGNATURE

____
RELATIONSHIP

____
DATE **TIME**

Assessment