Health Information Update (17 Years Old)

How many ounces of milk do you drink/day? ____ Ounces What kind? _____________

Do you drink milk with meals? Yes ◯ No ◯

How many meals per day do you eat? ____ How many snacks per day? ________

How many servings/**DAY** do you have of: ___Cheese/Yogurt _____Fruits ___Veggies

How many servings/**DAY** do you have of: ____ Whole Grains ____Grains

How many servings/**WEEK** do you have of: ___Red Meat ____White Meat

How many servings/**WEEK** do you have of: ____Fish ___Eggs ___Peanut butter ___Beans

How many ounces/**DAY** do you have of: _____Juice _____Pop

How often do you eat sweets? ◯15 >x/wk ◯ 8-14x/wk ◯ <8x/wk

OUTPUT

How many stools do you have per week? ______ What is the consistency? _________________

Do you see any blood in the stool? ◯Yes ◯ No

SLEEP

Do you have a bedtime routine? ◯ Yes ◯ No Is reading part of the bedtime routine? ◯Yes ◯No

Is there a TV or computer in your room? ◯Yes ◯ No

Do you watch the screen or play on a computer before or at bedtime? Yes◯ No ◯

Bedtime ______ pm Wake time ______am

Weekday : Bedtime ______ pm Wake time ______am

Weekend: Bedtime ______ pm Wake time ______am

Any sleep problems? ◯Yes ◯No Explain: ____

SAFETY

Do you use a seat belt? Yes ◯ No ◯

Where do you sit in the car? ◯Back seat ◯Front seat

Wear a helmet? ◯ Yes ◯ No What do you use a helmet for? _________________________

CHILDCARE/SCHOOL

Who are you home with after school? ◯Parent ◯Babysitter ◯Family member ◯After school care

What grade? _______________ Name of school:________________

How are grades? _______________

Do you work? ◯Yes ◯ No If yes, what type of work? _______________ How many hours/week? ___

Concerns: ____

BEHAVIOR/DEVELOPMENT

Describe your temperament ____

How do your parents discipline you when needed? ____

OTHER

How many hours of screen time does your child watch/day? School day ___ hrs Non-school day___ hrs

How much physical activity does your child get? ______minutes/day **OR** ____hours/week

What activities/hobbies does your child participate in? ______________________________________

How many times per day does your child brush his/her teeth? _________ Flosses? _______ per week

When was your last visit to the dentist? _______________

Any cavities ever? ◯Yes ◯ No Any cavities in the last year? ◯Yes ◯ No

What is your water source? ○ City ○ Community well ○ Personal well ○ Bottled water
Do you drink the tap water? ○ Yes ○ No
List any medications or vitamins/supplements your child takes: ______________________________
Do you need any medication refills? ____
Concerns? ____

Pediatric Symptom Checklist – Parent

Please mark under the heading that best fits your child:

	Never	Sometimes	Often
1. Fidgety, unable to sit still……..………..………….	____	________	_____
2. Feels sad, unhappy………………..…………….....	____	________	_____
3. Daydreams too much………...…………………….	____	________	_____
4. Refuses to share……...…..………………………….	____	________	_____
5. Does not understand others people's feelings..….	____	________	_____
6. Feels hopeless………..…………..…………………	____	________	_____
7. Has trouble concentrating…..………………………	____	________	_____
8. Fights with other children…………………………..	____	________	_____
9. Is down on him or herself..………………………….	____	________	_____
10. Blames others for his or her troubles………………	____	________	_____
11. Seems to have less fun..……………………………	____	________	_____
12. Does not listen to rules…..…………………………..	____	________	_____
13. Acts as if driven by a motor..………………………..	____	________	_____
14. Teases others…………..……………………………..	____	________	_____
15. Worries a lot…………..………………………………	____	________	_____
16. Takes things that do not belong to him or her…….	____	________	_____
17. Distracted easily………………………………………	____	________	_____

Pediatric Symptom Checklist – Youth

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Fidgety, unable to sit still…….………..………….	____	________	_____
2. Feels sad, unhappy……………….…………….....	____	________	_____
3. Daydreams too much………..…………………….	____	________	_____
4. Refuses to share……...…..………………………….	____	________	_____
5. Does not understand others people's feelings..….	____	________	_____
6. Feels hopeless……….…………..…………………	____	________	_____
7. Has trouble concentrating…..……………………….	____	________	_____
8. Fights with other children…………………………..	____	________	_____
9. Is down on him or herself..………………………….	____	________	_____
10. Blames others for his or her troubles………………	____	________	_____
11. Seems to have less fun..…………………………….	____	________	_____
12. Does not listen to rules….…………………………..	____	________	_____
13. Acts as if driven by a motor..………………………..	____	________	_____
14. Teases others………….……………………………..	____	________	_____
15. Worries a lot………..………………………………	____	________	_____
16. Takes things that do not belong to him or her…….	____	________	_____
17. Distracted easily…………………………………….	____	________	_____

Adolescent Questionnaire – YOUTH

*(For adolescent to complete)

Please answer ***ALL*** the questions below.

	Question			
1.	In, general, are you happy with the way things are going for you?	Yes	Sometimes	No
2.	Do you get along with your family?	Yes	Sometimes	No
3.	Do you go to school regularly?	Yes	Sometimes	No
4.	Do you have at least one adult you can really talk to?	Yes	Sometimes	No
5.	Do you feel you are about the right weight for your height?	Yes	Sometimes	No
6.	Have you ever tried to lose weight by taking diet pills or laxatives, making yourself vomit (throw up) after eating or starving yourself?	Yes	Sometimes	No
7.	Do you smoke cigarettes or chew tobacco?	Yes	Sometimes	No
8.	Do you drink alcohol?	Yes	Sometimes	No
9.	Have you ever driven a car drunk, high or while texting or ridden in a car with a driver who was?	Yes	Sometimes	No
10.	Have you tried any drugs (pot, crack, cocaine, heroin, speed, acid)?	Yes	Sometimes	No
11.	Have you ever used someone else's prescription (from a doctor or other health care provider) or non-prescription (from a store) drugs to sleep, stay awake, calm down or get high?	Yes	Sometimes	No
12.	Do you – or does anyone you live with – have a gun or carry a gun?	Yes	Sometimes	No
13.	Are you – or have you been - in a gang?	Yes	Sometimes	No
14.	Are you worried about money, a place to live, or having enough food to eat?	Yes	Sometimes	No
15.	Have you ever had any type of sex (vaginal, anal or oral sex)?	Yes	Sometimes	No
16.	Have you ever been attracted to the same sex (girl to girl/guy to guy) or do you feel that you are gay, lesbian or bisexual?	Yes	Sometimes	No
17.	Have you ever been tested for or diagnosed with a sexually transmitted disease (herpes, gonorrhea, chlamydia, genital warts, etc.)?	Yes	Sometimes	No
18.	Do you often feel very sad or down as though you had nothing to look forward to?	Yes	Sometimes	No
19.	Do you have serious problems or worries at home or school?	Yes	Sometimes	No
20.	Have you ever had thoughts about killing yourself?	Yes	Sometimes	No
21.	Do you feel afraid in any of your relationships?	Yes	Sometimes	No
22.	Have you been threatened, teased or hurt by someone (on the web, by text, or in person) or has anyone make you feel sad, unsafe, or afraid?	Yes	Sometimes	No
23.	Have you ever been physically or sexually abused or mistreated by anyone (kicked, hit, pushed, forced or tricked into having sex, touched on you private parts)?	Yes	Sometimes	No

Menses Questionnaire

*(For females to complete if they have started menstruation)

When did you start your period for the 1st time? _______________ years/old

When was your last period? ______________

How often do you get your period? Every ______________ days

How many days does your period last? __________________ days

How is the flow? (Heavy, moderate, light) _______________________

Do you get cramps? ___ Always ___Sometimes ___Never

Are your cramps severe? __ Yes ___No

What do you do to help your cramps? (Take medicine, heating pad, etc.)
____

What do you use? ___Tampons ___Pads ___Both

Do you know what Toxic Shock Syndrome is and its cause? ___Yes ___No