Health Information Update (14 Years Old)

INTAKE

How many ounces of milk does your child drink/day? _____ Ounces What kind? _____

How many meals per day does your child eat? ____ How many snacks per day? _____

How many servings/**DAY** does your child have of: _____Fruits _____Veggies _____ Whole Grains

How many servings/**DAY** does your child have of: _____ Cheese/yogurt

How many servings/**WEEK** does your child have of: ___ Meat ___Beans ___Nuts ___Eggs ___ Fish

How many ounces/**DAY** does your child have of: _____Juice _____Pop

How often does your child eat sweets? ◯ 15 or more x/wk ◯ 8-14x/wk ◯ <8x/wk

OUTPUT

How many stools does your child have per week? _____ What is the consistency? _____

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

SLEEP

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

Does your child watch the screen or play on a computer before or at bedtime? ◯ Yes ◯ No

Does your child read at night? Yes ◯ No ◯

Weekday : Bedtime _____ pm Wake time _____am

Weekend: Bedtime _____ pm Wake time _____am

Any sleep problems? ◯ Yes ◯ No Explain: _____

SAFETY

Does your child use a seat belt? ◯ Yes ◯ No

Wear a helmet? ◯ Yes ◯ No

SCHOOL

Who is with your child home with after school? ◯ Mom ◯ Dad ◯ Family member ◯ Self

Name of school:_____ What grade? _____

How are grades? _____ Concerns: _____

What does your child want to be when he/she grows up? _____

BEHAVIOR/DEVELOPMENT

Describe your child's temperament _____

How do you discipline your child when needed? _____

OTHER

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

How many minutes/ day does your child get physical activity? ◯ 0-15min ◯ 15-30 min ◯ 30-60 min

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 child's last visit to the dentist? _____ Any cavities? ◯ 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.

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