Health Information Update (11 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 before going to bed? ◯ 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

Where does your child sit in the car? ◯ Back seat ◯ Front seat

Wear a helmet? ◯ Yes ◯ No

CHILDCARE/SCHOOL

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

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

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……	____	_____	_____

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