Health Information Update (12 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

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

CHILDCARE/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 (happy, fussy, calm, etc.) _________________________________

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's 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