PEDIATRIC FORM AGE 6 years or older

Nutritional review

What kind of snacks does this child eat? Are meals at regular times? __yes __no

Social-personal

Who does child live with? __both parents __ Mom __Dad __Other _______________

Does child get along well in school? __yes __no if no have you identified problem? _____________________

Have you met with teacher to address problem ____________________________

List concerns or behavioral problems:

Does your child get along with family members? __yes __no ________________________________

Has your child been sick more than 10 days in the past year? __yes __no

System review (check all that apply)

__frequent or severe headaches
__dizzy or fainting spells
__black outs or convulsions
__eye problems or trouble seeing
__ear problems or trouble hearing
__coughing or wheezing
__easy bruising
__swelling or lumps anywhere on body
__pain or swelling in joints, back or muscles
__not moving arms or legs
__staggering or weakness
__tingling in feet or hands
__loss of memory
__loss of appetite
__dental cavities
__problems with swallowing or digestion
__pain in stomach or abdomen
__change in bowel habits
__blood in vomit
__black or bloody bowel movements

__fevers
__nose, mouth,throat problem or trouble speaking
__chest pain or pressure
__shortness of breath or trouble breathing
__swelling of ankles
__rapid heartbeat or skipped beats
__difficulty or pain when urinating
__urination color chang or frequency
__pain or soreness on genitals or drainage from penis
__itching or irritation of genital area or vaginal discharge
__increased tension or nervousness
__trouble sleeping or nightmares
__change in weight (over/under)
__allergies
__rash or skin problems
__failure to use car seat or automobile seat belt
__has not been screened for sickle cell (if non-white)