Complete for Ages 7-18

Name: **Your Overall Feeling** ❑ Excellent ❑Very Good ❑ Good ❑Fair ❑ Poor **Do you feel safe at home?**❑ Yes ❑ No

Do you have any specific concerns today? _____

What is your child's pain level? Where does it hurt if at all?

Is patient or parent currently in a situation where they are being verbally or physically hurt, threatened or made to feel afraid? ❑ Yes ❑ No

Does the patient have any of these symptoms at the present time:

❑ Fever	❑ Nasal Discharge	❑ Eye Discharge	❑ Wheezing	❑ Abdominal Pain
❑ Headache	❑ Earache	❑ Sore Throat	❑ Vomiting	❑ Decrease in Appetite
❑ Nasal Congestion	❑ Pulling at Ears	❑ Cough	❑Diarrhea	❑ Rash

Please list all medications (including OTC, Herbals, and Supplements)	Please list allergies (drug, flood, latex)
Are you enrolled in RELAYHEALTH so that you can e-mail your provider? ❑Yes❑No **Please provide your e-mail so we can enroll you in Relay Health:**	❑ No Allergies

Chronic Medical Conditions	**Surgeries/Hospitalizations (Dates)**	**Family History (biological siblings, parents, grandparents)**	**TB Questionnaire**
			Has a family member or contact had tuberculosis? ❑ No ❑Yes Has a family member had a positive tuberculin skin test? ❑ No ❑ Yes Was your child born in a high-risk country? ❑ No ❑ Yes Has your child traveled to a high risk country for more than one week? ❑No ❑ Yes

In the age group below that is closest to your child's age, please check the actions your child does: Developmental Behavior

7-18 Years	**12-18 Year Olds (Please have the patient complete)**	
❑Does Chores when asked ❑Gets along with family and friends ❑Engages in after-school activities ❑Reading and doing math at grade level ❑Eats healthy food and snacks ❑Positive self-image	Over the past TWO weeks, how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things. 0= Not at all 1= Several days 2= More than half the days 3= Nearly every day 2. Feeling Depressed, or Hopeless 0= Not at all 1= Several days 2= More than half the days 3= Nearly every day	Are you thinking about Suicide? ❑ Yes ❑ No Are you thinking about Homicide? ❑ Yes ❑ No
For Females First Menstrual Period (what age) Last Menstrual Period Do periods occur monthly ❑ Yes ❑ No How many days do periods last?		