Christian Health Care Center
ESTABLISHED 1911

HEALTH, NUTRITION, AND PAIN SCREEN
CHILD/ADOLESCENT

Patient name _____

MR# _____

PLEASE CHECK ***"YES"*** IF YOUR CHILD HAS HAD PROBLEMS, ***"NO"*** IF NOT, AND INDICATE IF THE CONDITION HAS BEEN TREATED IN ANY OF THE FOLLOWING

Condition	Check Here	Was it treated?	Comments, as appropriate
Allergies, specify	☐Yes ☐No	☐Yes ☐No	
Medication sensitivity	☐Yes ☐No	☐Yes ☐No	
Anemia	☐Yes ☐No	☐Yes ☐No	
Arthritis	☐Yes ☐No	☐Yes ☐No	
Asthma	☐Yes ☐No	☐Yes ☐No	
Bleeding ulcers	☐Yes ☐No	☐Yes ☐No	
Cancer or tumor	☐Yes ☐No	☐Yes ☐No	
Diabetes	☐Yes ☐No	☐Yes ☐No	
Emphysema	☐Yes ☐No	☐Yes ☐No	
Glaucoma	☐Yes ☐No	☐Yes ☐No	
Gout	☐Yes ☐No	☐Yes ☐No	
Epilepsy	☐Yes ☐No	☐Yes ☐No	
Heart problems, specify	☐Yes ☐No	☐Yes ☐No	
Head injury	☐Yes ☐No	☐Yes ☐No	
High blood pressure	☐Yes ☐No	☐Yes ☐No	
Kidney/bladder	☐Yes ☐No	☐Yes ☐No	
Polio	☐Yes ☐No	☐Yes ☐No	
Rheumatism	☐Yes ☐No	☐Yes ☐No	
Rheumatic fever	☐Yes ☐No	☐Yes ☐No	
Seizure	☐Yes ☐No	☐Yes ☐No	
Skin condition	☐Yes ☐No	☐Yes ☐No	
Stomach/intestinal ulcer	☐Yes ☐No	☐Yes ☐No	
Thyroid disease	☐Yes ☐No	☐Yes ☐No	
Tuberculosis	☐Yes ☐No	☐Yes ☐No	

Other? (Please specify and indicate if your child has been treated for this condition(s)). _____

_____

_____

Has your child had any difficulty with the following in the past year?

GENERAL				
				Comments, as appropriate
Energy	High	Low	Normal	
Sleep	Increased	Decreased	Normal	

Condition	Check Here	Was it treated?	Comments, as appropriate
Fever	☐Yes ☐No	☐Yes ☐No	
Change in hair	☐Yes ☐No	☐Yes ☐No	
Body pigmentation change	☐Yes ☐No	☐Yes ☐No	
Rash	☐Yes ☐No	☐Yes ☐No	

HEIGHT_____ **WEIGHT**_____

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NUTRITIONAL STATUS			
Condition	**Check Here**	**Was it treated?**	**Clinician comments, as appropriate**
Difficulty chewing	☐Yes ☐No	☐Yes ☐No	
Difficulty swallowing	☐Yes ☐No	☐Yes ☐No	
Weight change (5% in a month,10% in 6 months)	☐Yes ☐No	☐Yes ☐No	
Recent change in diet/appetite	☐Yes ☐No	☐Yes ☐No	
Current Diagnosis of Anorexia	☐Yes ☐No	☐Yes ☐No	
Current Diagnosis of Bulimia	☐Yes ☐No	☐Yes ☐No	
Dialysis	☐Yes ☐No	☐Yes ☐No	
Severe nausea/vomiting/diarrhea for greater than 5 days	☐Yes ☐No	☐Yes ☐No	
Eating inedible substances-Pica (clay, corn starch, paper)	☐Yes ☐No	☐Yes ☐No	
Obesity (BMI greater than 35) Note: See chart last page	☐Yes ☐No	☐Yes ☐No	
Modified or Therapeutic Diet Identification	☐Yes ☐No	☐Yes ☐No	
Medications that warrant a diet instruction MAOI, Lithium Oral Corticosteroid, Cholesterol Lowering Agents, Lasix, Dyazide, Bumex	☐Yes ☐No	☐Yes ☐No	
Gastric Bypass	☐Yes ☐No	☐Yes ☐No	
Pregnancy (Adolescent/Teen)	☐Yes ☐No	☐Yes ☐No	
Very Limited Milk Intake	☐Yes ☐No	☐Yes ☐No	
Recent low blood iron levels	☐Yes ☐No	☐Yes ☐No	
Very limited intake of a variety of foods including • protein based foods • fruits and vegetables	☐Yes ☐No	☐Yes ☐No	

ACTIVITIES OF DAILY LIVING		
Normal age of onset	**Check Here**	**Clinician comments, as appropriate**
Walking	☐Yes ☐No	
Toileting	☐Yes ☐No	
Dressing	☐Yes ☐No	
Talking	☐Yes ☐No	

HEAD			
Condition	**Check Here**	**Was it treated?**	**Clinician comments, as appropriate**
Trauma/injury	☐Yes ☐No	☐Yes ☐No	
Headache	☐Yes ☐No	☐Yes ☐No	
Sinus pain	☐Yes ☐No	☐Yes ☐No	
Light headed/dizzy	☐Yes ☐No	☐Yes ☐No	

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EYE, EAR, NOSE, THROAT			
Condition	**Check Here**	**Was it treated?**	**Comments, as appropriate**
Glasses or contacts	☐Yes ☐No	☐Yes ☐No	
Double vision	☐Yes ☐No	☐Yes ☐No	
Blurred vision	☐Yes ☐No	☐Yes ☐No	
Trouble with vision	☐Yes ☐No	☐Yes ☐No	
Unusual sounds in ears	☐Yes ☐No	☐Yes ☐No	
Sore throat	☐Yes ☐No	☐Yes ☐No	
Hoarseness	☐Yes ☐No	☐Yes ☐No	
Swollen glands	☐Yes ☐No	☐Yes ☐No	
Mouth problems specify	☐Yes ☐No	☐Yes ☐No	
Dental problems specify	☐Yes ☐No	☐Yes ☐No	
GASTROINTESTINAL/GENITOURINARY			
Condition	**Check Here**	**Was it treated?**	**Comments, as appropriate**
Vomiting	☐Yes ☐No	☐Yes ☐No	
Nausea	☐Yes ☐No	☐Yes ☐No	
Blood in vomit	☐Yes ☐No	☐Yes ☐No	
Blood in stool	☐Yes ☐No	☐Yes ☐No	
Tarry stool	☐Yes ☐No	☐Yes ☐No	
Diarrhea	☐Yes ☐No	☐Yes ☐No	
Bedwetting	☐Yes ☐No	☐Yes ☐No	
Blood in urine	☐Yes ☐No	☐Yes ☐No	
Vaginal discharge	☐Yes ☐No	☐Yes ☐No	
Urinary problems specify	☐Yes ☐No	☐Yes ☐No	
Date of first menses	☐Yes ☐No	☐Yes ☐No	
Menstrual difficulty	☐Yes ☐No	☐Yes ☐No	
Date of last: Menses	/ /		
Date of last: Pap smear	/ /		
Date of last: Mammogram	/ /		
CARDIOVASCULAR			
Condition	**Check Here**	**Was it treated?**	**Comments, as appropriate**
Irregular heartbeat	☐Yes ☐No	☐Yes ☐No	
Pounding/racing heart	☐Yes ☐No	☐Yes ☐No	
Ankle swelling	☐Yes ☐No	☐Yes ☐No	
Chest pain/pressure	☐Yes ☐No	☐Yes ☐No	
RESPIRATORY			
Condition	**Check Here**	**Was it treated?**	**Comments, as appropriate**
Cough	☐Yes ☐No	☐Yes ☐No	
Shortness of breath	☐Yes ☐No	☐Yes ☐No	
Bloody sputum	☐Yes ☐No	☐Yes ☐No	

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PSYCHOLOGICAL/NEUROLOGICAL				
Symptom	**Yes**		**No** Check Here	**Comments, as appropriate**
	Past	**Currently**		
Thoughts of suicide				
Thoughts of homicide				
Anxiety attacks				
Drug/alcohol use				
Unusual smells or tastes				
Dizziness				
Fainting				
Loss of feeling				
Paralysis				
Weakness				
Seizures				

Primary care physician/pediatrician _____

Address _____

Phone _____ Date of last physical _____

Does your child take any medications? ☐Yes ☐No If Yes, complete page 5

Has your child received all recommended immunizations? ☐Yes ☐No

Does your child use alternative medicine or other therapies? (i.e. vitamins, herbs, supplements)☐Yes ☐No
If yes, when _____

Has your child ever been in counseling or therapy? ☐Yes ☐No
If yes, when _____

Reason _____

Does your child use alcohol? ☐Yes ☐No If yes, give approximate weekly intake _____

Does your child use tobacco? ☐Yes ☐No
If yes, give approximate weekly intake _____

Does your child use recreational drugs? ☐Yes ☐No
If yes, specify what and approximate weekly intake _____

Has your child ever been hospitalized? ☐Yes ☐No
If yes, give approximate dates and reasons _____

Does your child have any history of pain management for a chronic condition? ☐Yes ☐No
If yes, give approximate dates and reasons _____

Is there any known history of infections caused by drug resistant organisms? ☐ Yes ☐ No
If yes, please describe _____

Physician Comments _____

_____

_____

_____

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MEDICATIONS

Are you taking medications? ☐ Yes ☐ No **If yes, please fill in remaining information. If no, skip to next page.**

Prescription insurance _____

Preferred pharmacy name _____

Pharmacy address _____ Fax _____

Copy of card presented to office staff? ☐Yes ☐No

Adverse and allergic reactions (include medications, foods, latex, and allergies) _____

_____

_____

_____

Please list out all **prescribed medications** and **non-prescribed medications** (vitamins, herbal products, alternative/complimentary medications/treatments, over-the-counter, supplements, etc.)

Name	Date	Reason for medication	Dosage/frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

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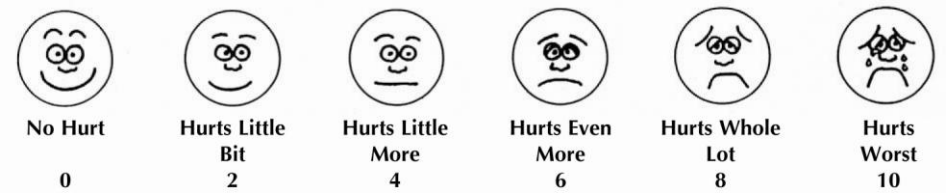
Is your child currently experiencing pain? ☐Yes ☐No

If yes, please answer the following questions

Indicate severity of pain on a scale of 1 to 10 (10 most severe)



Location of pain _____

Current treatment for pain _____

Medication(s) taken for pain _____

Physician comments _____

Guardian signature _____ **Date**_____

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DO NOT FILL OUT BELOW THIS LINE

This form reviewed with client/parent/guardian. ☐ Yes ☐ No

Clinician's signature _____ Date/Time_____

- If answers indicate current, untreated medical and/or pain problems or
- If answer indicates that appropriate immunizations have not been administered or
- If the date of the last physical exam is greater than one year ago, appropriate referrals to be made as follows

Secure medical information from personal physician/pediatrician. _____

Ask personal physician/pediatrician to repeat physical examination. _____

Refer to pediatrician for evaluation and/or administration of appropriate immunizations _____

Refer to neurologist for neurological examination. _____

Refer to psychiatrist for further evaluation of physical and mental status. _____

Refer back to personal physician/pediatrician prior to continued treatment._____

Refer for rehabilitation assessment. _____

Refer for pain management. _____

- If nutritional response indicates significant changes in appetite, weight or associated problems (i.e., failure to thrive) referrals to be made as follows

Refer for nutritional assessment and/or pediatrician's evaluation_____

☐ No need for physician follow up

_____ _____

Physician signature Date/Time