Today's Date: _____

CLACKAMAS Health Centers

Name: _____
DOB: ___/___/____ Sex: M__ F__ T__
MRN: _____ (or place label here)

Pediatric Health Assessment

(Ages 5-11) – FOR PARENT/GUARDIAN

Please answer these questions to help us get to know your child better and together we can plan the best care for your child. It is okay to skip any questions you are not comfortable answering.

GENERAL MEDICAL INFORMATION

In the last year, have there been any changes to your child's health or any hospital visits? ..... YES ❑ NO ❑
If yes, describe:

Has your child had an allergic reaction (bad effect) from any of the following?

❑ No known allergies ❑ Medicines/Drugs (please describe) _____
❑ Latex (rubber gloves) ❑ Eggs ❑ Peanuts ❑ Bee stings ❑ Shellfish
❑ Other (please describe) _____

Is your child taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements)? ..... YES ❑ NO ❑
If yes – please list:

PHYSICAL AND ORAL HEALTH

1. Are there times when your family does not have enough food to eat? ..... YES ❑ NO ❑
2. Does your child eat 5 servings of fruits and vegetables each day? ..... NO ❑ YES ❑
3. Does your child have more than 8 oz (1 cup) of juice or soda per day? ..... YES ❑ NO ❑
4. Does your child eat fast food more than once per week? ..... YES ❑ NO ❑
5. Does your child exercise (play hard - like running or sports) for more than 30 minutes every day? ..... NO ❑ YES ❑
6. How many hours per day does your child watch TV, go on the internet/phone or play video games? ❑ 0-1 ❑ 1-2 ❑ Greater than 2
7. Have you talked to your child about puberty? ..... NO ❑ YES ❑
   If no, would you like to talk about it today? _____
8. Does your child have trouble with constipation or bedwetting? ..... YES ❑ NO ❑
9. Does your child brush teeth twice daily and floss once a day? ..... NO ❑ YES ❑
10. When was the last dentist check-up? _____

SAFETY AND INJURY PREVENTION

11. When riding in a car, does your child use a seatbelt or booster seat? ..... NO ❑ YES ❑
12. Does your child always wear a helmet when riding a bike, skateboard, roller blades, or scooter? ..... NO ❑ YES ❑
13. Does your child know how to swim? ..... NO ❑ YES ❑
14. Are there guns in your home or anywhere else your child spends time? ..... YES ❑ NO ❑
15. Do you have a fire and earthquake emergency plan? ..... NO ❑ YES ❑
16. Do you teach your child how to be safe on the internet? ..... NO ❑ YES ❑

SCHOOL AND FRIENDS

17. Do you have any concerns about your child's learning or behavior in school? ... YES ❑ NO ❑

FLIP OVER FOR ADDITIONAL QUESTIONS

18. Does your child have at least one friend? ..... NO ❑ YES ❑

19. How much school has your child missed in the last month for any reason?
❑ None ❑ 1-3 days ❑ 3 or more days

20. What does your child do after school?

EMOTIONAL WELL BEING

21. Who lives in your child's home?

22. Do you have any worries about your child's mood or behavior?
(example – hyperactive, angry, sad, withdrawn, scared, shy, or irritable) ..... YES ❑ NO ❑

23. Does your child have any problems with sleep or nightmares? ..... YES ❑ NO ❑

24. Does anyone bully or pick on your child, online or at school? ..... YES ❑ NO ❑

RISK REDUCTION/CONCERNS

25. Do you talk to your child about the risks of drugs, alcohol, and sexual activity? ...NO ❑ YES ❑

26. Do you have any worries about your child's behavior? ..... YES ❑ NO ❑

27. Does anyone in your child's house smoke cigarettes? ..... YES ❑ NO ❑

28. We know that what is happening in a child's life can affect their health.
Have **you, your child or your family** been
affected by any of these in the last year? ..... YES ❑ NO ❑

–Move, deportation or eviction
–Divorce, break-up or separation
–Death or violence
–Drug or alcohol abuse
–Threats, abuse, or neglect
–Prison/Jail
–DHS involvement/foster care
–Mental illness (depression, anxiety, bipolar disorder, suicide attempt)
–Racism or discrimination

STRENGTHS

Check off all the items that you think are true for your child.

❑ Our family helps and supports each other.
❑ My child likes to read.
❑ My child works hard in school, sports, or other activities.
❑ My child feels good about him or herself.
❑ My child has these healthy behaviors (like exercise, healthy eating):_____
❑ My child/family is involved in my community (religious, sports, service, family, or neighborhood).
❑ These things make me proud of my child: _____
❑ Others:_____

ADDITIONAL CONCERNS

Are there any other questions or concerns you would like to discuss today?

Signature: _____ (Parent/Guardian)

for office use: Provider

Reviewed by: _____ Date: _____

Rev. 6/13/23