NOVANT HEALTH

Appt Date________________ 10 year Check Up

Patient Name_____________________________________ DOB____________________________

Name of person filling out form _______________________ Phone number____________________

Nutrition:

How many cups of milk does your child drink per day? ____

How many cups of juice does your child drink per day?____

How many cups of water does your child drink per day?____

How many cups of soda does your child drink per day?____

Does your child eat a variety of meats, fruits, and vegetables each day?____________________________

Bowel/Bladder:

Any concerns about your child's voiding or stooling?____

Sleep:

How many hours does your child sleep at night? ____

Hearing/ Vision:

Any concerns about your child's hearing or vision?____

Social hx:

How much screen time does your child get each day? ____

What school does your child attend?_____________________________________ What grade?____________

Does your child do well in school?______________ Any concerns?_________________________________

What activities/hobbies does your child enjoy?____

Advice and Guidance for Parents: *(please check off as you read)*

___ Safety: Accidents remain the main cause of injury; always use seatbelts when riding in a car. Keep dangerous things like firearms, matches, and alcohol away from your child.

___Promote self-responsibility; assign age-appropriate chores, including responsibility for personal belongings, and encouraging developmentally appropriate decision making.

___Be prepared to answer questions and discuss information learned in family life.

___Wear SPF 30 or greater for sun exposure

___Be sure your child brushes his/her teeth at least twice a day. Regular dental exams are important.

___Smoke Exposure: Minimize your child's exposure to cigarette smoke

___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____

___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___

___Limit screen time to no more than 2 hours per day. You should not put a TV in your child's room.

___Nutrition: Your child should have at least 3 servings of dairy every day for calcium, limit sugar drinks, and encourage your child to choose nutritious foods and snacks. Packing your child's school lunch is also encouraged.

___ Sleep: Your child should have at least 9½ hours of sleep every night.

___ Behavior: Anticipate challenges to parental rules and authority, conflicts over issues of independence, and moodiness

(for podcasts on Behavior, go to www.shotshurtless.com)

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1	___	___	___
2. Spends more time alone	2	___	___	___
3. Tires easily, has little energy	3	___	___	___
4. Fidgety, unable to sit still	4	___	___	___
5. Has trouble with teacher	5	___	___	___
6. Less interested in school	6	___	___	___
7. Acts as if driven by a motor	7	___	___	___
8. Daydreams too much	8	___	___	___
9. Distracted easily	9	___	___	___
10. Is afraid of new situations	10	___	___	___
11. Feels sad, unhappy	11	___	___	___
12. Is irritable, angry	12	___	___	___
13. Feels hopeless	13	___	___	___
14. Has trouble concentrating	14	___	___	___
15. Less interested in friends	15	___	___	___
16. Fights with other children	16	___	___	___
17. Absent from school	17	___	___	___
18. School grades dropping	18	___	___	___
19. Is down on him or herself	19	___	___	___
20. Visits the doctor with doctor finding nothing wrong	20	___	___	___
21. Has trouble sleeping	21	___	___	___
22. Worries a lot	22	___	___	___
23. Wants to be with you more than before	23	___	___	___
24. Feels he or she is bad	24	___	___	___
25. Takes unnecessary risks	25	___	___	___
26. Gets hurt frequently	26	___	___	___
27. Seems to be having less fun	27	___	___	___
28. Acts younger than children his or her age	28	___	___	___
29. Does not listen to rules	29	___	___	___
30. Does not show feelings	30	___	___	___
31. Does not understand other people's feelings	31	___	___	___
32. Teases others	32	___	___	___
33. Blames others for his or her troubles	33	___	___	___
34. Takes things that do not belong to him or her	34	___	___	___
35. Refuses to share	35	___	___	___

Total score ___________

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?____