

6-10 Years

Department of State Health Services Child Health Record Preventive Health Visit

Client Information

Name: _____
DOB: _____ / _____ / _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother _____ Father _____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Mental Health

(+ indicates need for further assessment)
_____ Sleep Problems _____ Special education classes
_____ Behavior/problems _____ No/excessive extracurricular activities
_____ Relationship problems with parents, siblings, peers _____ Substance abuse/use
_____ Problems in school _____ Self-concept problems
Grade Level _____
Comments:

Child's Health/Interim History

Allergies:
Does the system review note any problems or parent concerns: _____ Y _____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care/sealants:

Physical Examination

Temp _____ Pulse _____ Resp _____
BP _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____
BMI _____

N _____	A _____	NE _____	N _____	A _____	NE _____
_____ Appearance	_____ Head/fontanelles	_____ Skin/nodes	_____ Eyes	_____ Ears	_____ Nose
_____ Mouth/throat	_____ Teeth	_____ Neck	_____ Chest/breasts	_____ (Tanner stage)	_____ Heart/pulses
					_____ Lungs
					_____ Abdomen
					_____ Genitalia/anus
					_____ (Tanner stage)
					_____ Spine
					_____ Extremities

Neurologic:
_____ Muscle tone
_____ DTRs

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group* _____ Y _____ N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
_____ Dairy _____ Vegetables _____ Fruits
_____ Breads, cereal, rice, and pasta
_____ Meat, poultry, fish, eggs, and dry beans

Sensory

Vision Screen: _____ Normal _____ Abnormal
Hearing Screen: _____ Normal _____ Abnormal

Health Education

Injury Prevention
_____ Seat belt/auto safety
_____ Bicycles/ATV
_____ Athletics
_____ Water safety
_____ Smoke detectors
_____ Firearm safety
Behavior
_____ Substance abuse
_____ Tobacco use
_____ Security
_____ Discipline patterns
_____ Responsibility
Communication/conflict resolution
Health Promotion
_____ Limit TV viewing
_____ Passive smoking
_____ Regular exercise
_____ Pubertal changes/sexuality
_____ Dental care/sealants
Nutrition
_____ Healthy diet/snacks
_____ Junk food
_____ Iron-rich foods

Assessment

Plan

TB Risk Screening Tool: _____
Dental referral made: _____ Y _____ N
Immunizations: _____ Up to date _____ To be given today _____ Deferred
Explain:
Lab: Lead questionnaire (at 6 years): _____
Hct/Hgb _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

