Northwest PRIMARY CARE

13-14 YEAR
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB:_____ Male Female

Physician Signature:_____

Instructions: Please answer the questions below by choosing YES or NO.

General Health		
Do you have any concerns about your health today?	NO	YES
Do you receive healthcare from anyone besides a medical doctor(acupuncturist, herbalist, naturopath)?	NO	YES
Nutrition		
Do you eat 5 or more helpings of fruits or vegetables at every day?	YES	NO
Are your breads, pastas and cereals mostly whole grain?	YES	NO
Do you eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese, calcium-fortified orange juice, soymilk, or cereal)?	YES	NO
Do you eat more than 1 fast food meal per week?	NO	YES
Do you eat meals together as a family?	YES	NO
Do you drink sugary drinks (juice, soda, energy drinks)?	NO	YES
Do you have concerns or questions about the size or shape of your body?	NO	YES
In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives or starving yourself?	NO	YES
Oral Health		
Do you brush your teeth twice a day?	YES	NO
Do you floss your teeth at least once a day?	YES	NO
Have you been to the dentist in the last year?	YES	NO
School		
Are you having problems in school or work?	NO	YES
Are your grades worse than last year?	NO	YES
Trouble concentrating?	NO	YES
Fighting?	NO	YES
Homework problems?	NO	YES
Suspension in the last year?	NO	YES
Missing school or work?	NO	YES
Activity		
Do you watch TV, play video games, or spend time on the computer more than more than 2 hours per day(not including computer time for homework)?	NO	YES
Do you have a TV, computer, or video game system in your bedroom?	NO	YES
Do you participate in any physical activities such as walking, skateboarding, dancing, swimming or playing basketball at least 4 days per week?	YES	NO
Do you play competitive sports?	NO	YES
If yes, is there any family history of heart problems or sudden death?	NO	YES

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Injury Prevention		
Do you always wear a seat belt in the car?	◯ YES	◯ NO
Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile	◯ YES	◯ NO
Do you ever carry a gun?	◯ NO	◯ YES
Is there a gun in your home?	◯ NO	◯ YES
Tuberculosis		
Has a family member or contact had tuberculosis disease?	◯ NO	◯ YES
Has a family member had a positive TB skin test (PPD)?	◯ NO	◯ YES
Were you born in a high-risk country (countries other that the U.S., Canada, Australia, or Western Europe?	◯ NO	◯ YES
Have you traveled to a high-risk country for more than a week?	◯ NO	◯ YES
Emotional Wellbeing		
Do you worry a lot or feel overly stressed out?	◯ NO	◯ YES
When you are angry, do you do violent things?	◯ NO	◯ YES
Do you find yourself continuing to remember or think about an unpleasant experience that happened in the past?	◯ NO	◯ YES
During the past few weeks have you often felt sad or down, had difficulty sleeping, frequently felt irritable, or felt like you have nothing to look forward to?	◯ NO	◯ YES
Have you ever seriously thought about killing yourself, made a plan or actually tried to kill yourself?	◯ NO	◯ YES
Is there someone at home, school, or work that has made you feel afraid, threatened you, or hurt you?	◯ NO	◯ YES
Even with usual ups and downs, do you enjoy life?	◯ YES	◯ NO
Do you get along with your family?	◯ YES	◯ NO
Do you follow your family's rules?	◯ YES	◯ NO
Review of Systems: *Any **Concerns** about...*		
Eating habits, weight loss, or lack of energy?	◯ NO	◯ YES
Sleep problems, including excessive snoring?	◯ NO	◯ YES
Eye redness, excessive tearing, or discharge?	◯ NO	◯ YES
Recurrent ear, sinus or throat infections, nosebleeds?	◯ NO	◯ YES
Chest pain, shortness of breath, or irregular heartbeat?	◯ NO	◯ YES
Frequent colds, cough, wheezing, recurrent lung infections?	◯ NO	◯ YES
Abdominal pain, vomiting, diarrhea, constipation?	◯ NO	◯ YES
Kidney or bladder problems, infections, blood in the urine?	◯ NO	◯ YES
Birthmarks, skin rashes, itching, nail or hair problems?	◯ NO	◯ YES
Joint pain, stiffness, swelling, muscle pain or weakness?	◯ NO	◯ YES
Recurrent headaches, dizziness, tics, weakness, seizures?	◯ NO	◯ YES
Mood changes, sadness, nervous problems?	◯ NO	◯ YES
Excessive thirst or hunger, increased urination?	◯ NO	◯ YES
Paleness, anemia, easy bruising, swollen glands?	◯ NO	◯ YES
Puberty?	◯ YES	◯ NO
FOR FEMALES:		
Have you gotten your period?	◯ YES	◯ NO
Problems or questions about menstruation?	◯ NO	◯ YES
Do you get your periods monthly (21-35 days apart)? Date Last Period:	◯ YES	◯ NO