CHILD AND FAMILY CLINIC

HEALTH/NURSING ASSESSMENT

Name_____ Date of Birth_____ Date Completed _____

PHYSICAL HEALTH

Height _____ Weight_____ Eye Color _____ Hair Color _____

Cultural/Language Needs _____

MEDICAL HISTORY

Allergies: ☐ None ☐ Food ☐ Drug ☐ Environment ☐ Unknown

Other Allergies: _____

Allergic Reactions: _____

Immunizations (Adolescents) Up to date_____ Missing_____

Last PPD ☐ Positive ☐ Negative ☐ Unknown

Chest X-ray ☐ Yes ☐ No Comments_____

Alert/Illnesses Information:

☐ Diabetic	☐ Seizures	☐ Heart Condition	☐ Possible Pregnancy
☐ Tuberculosis	☐ Thyroid	☐ Ulcers	☐ Hepatitis
☐ Mumps	☐ Tendency to bleed	☐ Chicken pox	☐ Measles/Rubella
☐ Rheumatic Fever	☐ Respiratory	☐ Dizziness	☐ Head Injuries
☐ Blurred vision	☐ Ringing in ears	☐ Frequent Nausea	☐ Scarlet Fever
☐ High Blood Pressure		☐ Discomfort in chest	

☐ Other, specify_____

Current Medications and Dosages: _____

_____

_____

_____

Do you take your medications as prescribed? ☐ Yes ☐ No

Family Doctor (medical):_____ **Phone: (____) - _____ - _____**

Address: _____

Last Physical Examination Date _____ **With** _____

HEALTH HABITS

Appetite ☐ Decreased ☐ Increased ☐ Unchanged
Comment:_____

Sleep ☐ Decreased ☐ Increased ☐ Unchanged

Comment:_____

Energy Level ☐ Decreased ☐ Increased ☐ Unchanged
Comment:_____

Exercise ☐ Yes ☐ No
Comment: _____

Tobacco Use ☐ Yes ☐ No

Quantity_____ How Long_____

Drug Use ☐ Yes ☐ No If yes, please answer the following:

Alcohol use last drink _____ How Long _____

Last drug use _____ How Long _____

Have you ever felt you should cut down on drinking/drug use?
☐ Yes ☐ No ☐ N/A ☐ Unknown

Have people annoyed you by criticizing your drinking/drug use?
☐ Yes ☐ No ☐ N/A ☐ Unknown

Have you ever felt guilty about your drinking/drug use?
☐ Yes ☐ No ☐ N/A ☐ Unknown

Have you ever had a drink/drug in the morning to steady your nerves or rid hangover?
☐ Yes ☐ No ☐ N/A ☐ Unknown

Do you take any of you medication differently than prescribed?
☐ Yes ☐ No ☐ N/A ☐ Unknown

Do you take medications aside from the ones prescribed?
☐ Yes ☐ No ☐ N/A ☐ Unknown

FAMILY HISTORY

Biological Family (Include current age, if deceased age and cause of death

Patient _____

Mother _____

Father _____

Sibling _____

Sibling _____

Sibling _____

Sibling _____

Other _____

Family Illnesses (Indicate if biological family has had any of the following and include relationship to the patient being seen here).

Tuberculosis _____ **Diabetes** _____
High Blood Pressure _____ **Heart Problems** _____
Cancer _____ **Epilepsy** _____
Blood Disease _____ **Mental Illness** _____
Alcohol Use/Abuse _____ **Drug Use/Abuse** _____
HIV/AIDS _____ **Other** _____

ADL & RISK FACTORS

Do you need assistance with any of the following?

Walking Dressing Bathing Oral Hygiene
Elimination

Check all that apply Use of Cane Use of Walker Use of Other
Comments: _____

Client/Family Teaching Needs

Medication Information Problem Solving/Stress Management
Exercise/Rest Symptom Management
Other _____

If client is under 18 years old, please complete the following

BIRTH & DEVELOPMENT HISTORY

Please check if yes:

Pregnancy ☐ Prenatal Care ☐ Drugs/Alcohol/Cigarettes ☐ Illness/meds

Condition of Birth Birth Weight ___lbs ___oz

Delivery ☐ Normal ☐ Full Term ☐ Premature ☐ C Section

Infancy Problems ☐ Feeding ☐ Sleeping ☐ Responding to environment

Any complications in the hospital before going home?

_____

Milestones – Please provide age at which the child performed the following:

Walked without support ___ Spoke first word ____
Spoke 1st 3-word sentence ____ Toilet trained__ Urine___ Bowels____

Comments

_____

_____

PRESENT PROBLEMS OR SYMPTOMS
(Check those that pertain to you)

Hearing difficulties
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Visual problems
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Headaches
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Ear Infections
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Nosebleeds
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Colds
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Wets bed at night
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Wets self during the day
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Has bowel movements in bed at night
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Has uncontrollable bowel movements during the day
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Rocks in bed
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Rocks in a chair
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Complains of pains in the abdomen
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Is hyperactive
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Sucks his or her thumb
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Has trouble falling asleep
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Tires easily
☐ Not at all ☐ A little ☐ A fair amount ☐ Much ☐ Very Much

Please list any other physical symptoms or problems the child has, any surgery or hospitalizations._____

_____

_____

Name _____ **DOB:** _____ **Date:** _____