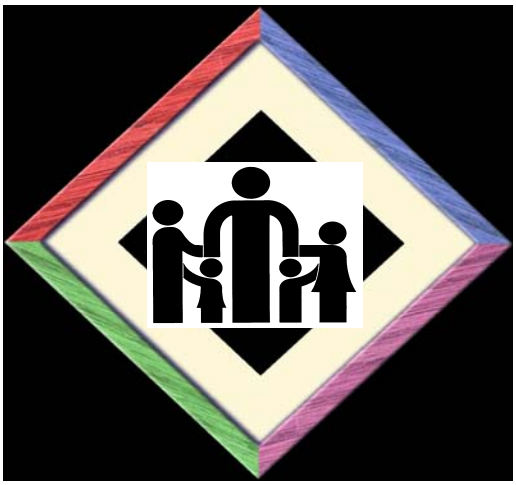
RIVERSIDE COUNTY DEPARTMENT OF PUBLIC HEALTH
Child Health and Disability Prevention Program

WELL CHILD ASSESSMENT
PACKAGE



NEWBORN CHILD
THRU
19 YEARS OF AGE

See Attachments
17 pages

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month Where was baby born?_____

How long was your pregnancy?_____Months If baby was born at home, were blood tests for newborn screening done? ☐YES ☐NO

Did you have any illness or problem? (Including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drug? (tobacco, alcohol, "Street drugs", over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital	YES	NO
Did you have a difficult/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1 st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐MALE ☐FEMALE Is this child adopted? ☐YES ☐NO Birth Weight:_____pounds _____ounces Length:_____inches

Has your child ever had:

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development or school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder or Kidney Problems, Wetting self or bed	YES	NO	(Girls) Has she started her period?	YES	NO
Constipation	YES	NO	(Girls) Are there problems with her period?	YES	NO

FAMILY HISTORY: Does mother (M), father(F), brother(B), sister(S), aunt(A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOUSEHOLD INFORMATION: Number of people in home:_____

Are both parents living in the home? ☐Yes ☐No

Does anyone in the home smoke, or use drugs or alcohol? ☐Yes ☐No

Language spoke in the home:

Do you live in a: ☐House ☐Apartment ☐Mobile Home ☐Shelter ☐Homeless

Patient Identification:

Signature:_____ **Date:**_____

Relationship to Child:_____

Reviewer's Signature:_____ **Date:**_____

Revised Date April 2010

HISTORIAL MEDICO DEL NIÑO

HISTORIAL MEDICO DE SU EMBARAZO CON ESTE NIÑO:

¿En qúe mes de su embarazo visitó usted por primera vez al doctor?_____mes ¿Dónde nació su bebé?_____.

¿De cuántos meses fue su embarazo?_____. Si nació el bebé en casa, ¿le hicieron análisis de sangre de detección básica para un recién nacido? ☐Sí ☐No

¿Tuvo usted alguna enfermedad o problemas? (Esto incluye enfermedades transmitidas sexualmente o enfermedades contagiosas)	Sí	No	¿Usó usted alguna droga? (Tabaco, bebidas alcohólicas, drogas de la calle, remédios caseros o de la farmacia)	Sí	No
¿Tomó usted alguna medicina recetada por su doctor?	Sí	No	¿Le dieron de alto a su bebé juntamente con usted?	Sí	No
¿Tuvo un parto difícil/anormal/cesárea?	Sí	No	¿Le nació a usted más de un bebé?	Sí	No
¿Tuvo el bebé algún problema durante la primera semana de vida?	Sí	No	¿Se le puso al bebé alguna vacuna para la Hepatitis B?	Sí	No

HISTORIAL MEDICO DEL NIÑO: ☐M ☐F ¿Fué adoptado este niño? ☐Sí ☐No Peso al nacer: ___lbs.___oz. La medida:_____pulgadas

¿Ha tenido alguna vez:

Sarampión, varicela, paperas, sarampión alemán	Sí	No	Vómitos después de comer, se rehúsa a comer	Sí	No
Tuberculosis o una prueba positiva de tuberculosis	Sí	No	Problemas de los músculos, articulaciones o huesos	Sí	No
Amigdalitis/Dolor de garganta	Sí	No	Problemas de la piel	Sí	No
Problemas con los ojos o con la vista	Sí	No	Dolores de cabeza o mareos	Sí	No
Problemas con los oídos o para oír	Sí	No	Convulsiones, ataques, epilepsia	Sí	No
Dificultad al respirar/roncar en la noche	Sí	No	Diabetes	Sí	No
Problemas del corazón	Sí	No	Problemas con la tiroides	Sí	No
Asma, bronquitis o pulmonía	Sí	No	Alergias	Sí	No
Anemia, problemas de hemorrágia, transfusiones de sangre	Sí	No	Problemas con el desarrollo o con el desempeño escolar	Sí	No
Dolores de estómago	Sí	No	Enfermedades o accidentes graves	Sí	No
Diarrea, manchándose con el excremento	Sí	No	Cirugía o hospitalización	Sí	No
Problemas con la vejiga o riñones, orinarse en la cama o ropa interior	Sí	No	(Niñas) ¿ Ha comenzado con su menstruación?	Sí	No
Estreñimiento/constipación	Sí	No	(Niñas) ¿ Hay problemas con su menstruación?	Sí	No

HISTORIAL MEDICO DE LA FAMILIA: Tiene alguien de la familia: madre (M), padre (P), hermano (HO), hermana (HA), tío (TO), tía (TA), abuela (AA), abuelo (AO)

			¿Cual miembro familiar?				¿Cual miembro familiar?
Sí	No	Diabetes		Sí	No	Alta presión de sangre	
Sí	No	Epilepsia o convulsiones		Sí	No	Trastornos sanguíneos	
Sí	No	Retraso mental		Sí	No	Tuberculosis	
Sí	No	Cáncer		Sí	No	Alergias	
Sí	No	Enfermedad de los riñones o urinaria		Sí	No	Problemas de los pulmones o con la respiración	
Sí	No	Problemas con los huesos o las articulaciones		Sí	No	Anormalidad funcional de los ojos	
Sí	No	Enfermedad del corazón		Sí	No	Anormalidad funcional de los oídos	

INFORMACIÓN SOBRE LOS PADRES:

	Madre:	Padre:
Edad:	_____	_____.
Estatura:	_____	_____.
Ocupación:	_____	_____.

INFORMACIÓN DOMICILIARIA: ¿Cuántas personas viven en su casa?____.

¿Viven ambos padres en la casa? ☐Sí ☐No

¿Alguien en la casa fuma o usa drogas o bebidas alcohólicas? ☐Sí ☐No

¿Qué idioma se habla en casa?_____.

¿Vives en ☐Casa ☐Apartamento ☐Refugio ☐Casa Remolque ☐Sin casa ni hogar

Identificación del Paciente:

Firma:_____**Fecha:**_____.

Parentesco con el niño:_____.

Firma Del Examinador:_____**Fecha:**_____.

Revised Date April 2010

Well Child Assessment - Under 1 Month

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:

Illness:

Problems:

Immunization Reaction:

Allergies:

Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ Momentarily lifts head while prone
- ☐ Regards face & follows 30°
- ☐ Responds to sounds by blinking, quieting, startle etc.
- ☐ Sleeps 3-4 hours
- ☐ Moves all extremities
- ☐ Awake 1 hr. or longer
- ☐ Resting position flexed posture

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Breast/Formula With Fe

Tobacco: Second-hand Smoke

Safety: Handling, Falling, Car Seat, Toys, Folk Remedies

Parenting: Spoiling, Sib. Rivalry, Sleep Patterns/Emergencies

Dental: Flouride/Cleaning Gums, No bottle in bed

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention/Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____

Well Child Assessment - 1 to 2 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Allergies:
Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ Vocalizes with cooing (musical sounds)
- ☐ Smiles Responsively
- ☐ Attentive to voices
- ☐ Shows interest in visual and auditory stimuli
- ☐ Lifts head, neck with forearm support while prone

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Breast/Formula, Solids, Vitamins with Fe

Tobacco: Second-hand Smoke

Safety: No shaking, Bath Safety, Smoke Detector, Burns, 911, Car Seats

Parenting: Spoiling, Sleep Patterns, Fever Control

Dental: Fluoride, Avoid Sweets, Clean Gums, Orthodontic Pacifier, No bottle in bed.

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk:_____

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed: _____

Developed by County of Riverside, CHDP Program

Revised Date April 2010

Well Child Assessment - 3 to 4 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Allergies:
Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ While prone lifts head and shoulders
- ☐ Laughs/Squeals
- ☐ Cooing/Vocalization
- ☐ Plays with and studies hands and feet
- ☐ Controls head well
- ☐ Grasps Rattle when placed in hand
- ☐ Shows feelings like surprise, anger, fear

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Breast/Formula, Solids, Vitamns with Fe

Tobacco: Second-hand Smoke

Safety: No shaking, Bath Safety, Smoke Detector, Burns, 911, Car Seats

Parenting: Spoiling, Sleep Patterns, Fever Control

Dental: Fluoride, Avoid Sweets, Clean Gums, Orthodontic Pacifier, No bottle in bed.

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed: _____

Well Child Assessment - 5 to 6 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Allergies:
Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ **Pulled to Sit-No head Lag**
- ☐ **Reaches for Objects**
- ☐ **Grasps Objects**
- ☐ **Smiles Spontaneously**
- ☐ **Rolls Over Both Ways**
- ☐ **Sits Briefly Alone**
- ☐ **Gums Objects**
- ☐ **Babble/Vocalizes with single consonants**
- ☐ **Turns to Sound**

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family

Nutrition: Breast/Formula, Vitamins with Fe, Cup

Tobacco: Second-hand Smoke

Safety: Play Pen, Poisoning, Safe High Chair, Child Proof Home. Bath Safety, Folk Remedies

Parenting: Talk, Play, Exercise, Bonding, Schedule (rising/bed time), Offers Cup, Fever Control.

Dental: Fluoride, Avoid Sweets, Clean Gums, No bottle in bed

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed:_____

Developed by County of Riverside, CHDP Program

Revised Date April 2010

Well Child Assessment - 7 to 9 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	Hgb/Hct:

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Allergies:
Parental Concerns:

DEVELOPMENT ☐ **Normal** ☐ **Abnormal**

☐ **Completed a standardized developmental screening tool**

PHYSICAL EXAMINATION **PM 160** ☐**Yes** ☐**No**

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Breast/Formula, Solids, Finger Foods, Cup, No Honey Corn Syrup

Tobacco: Second-hand Smoke

Safety: Nuts, Candy or Popcorn, Outlets, Stairs, Hot Water, Pools. Car Seats, Lead Pottery, Folk Remedies

Parenting: Baby Crawl/Stand, Appetite. Spanking/Shaking

Dental: Fluoride, Avoid Sweets. Teething ring, No Bottle in Bed

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed: _____

Well Child Assessment - 10 to 12 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:

Illness:

Problems:

Immunization Reaction:

Allergies:

Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ Stands Momentarily
- ☐ Takes few steps holding Furniture
- ☐ Plays with toys
- ☐ "Ma Ma", "Da Da"(Knows Specific)
- ☐ Responds to own name
- ☐ Thumb-Finger Grasp
- ☐ Holds Cup to Drink
- ☐ Plays with toys/Places Objects in container
- ☐ Plays Pat-a-Cake/Waves Bye-Bye, Understands No
- ☐ Imitates vocalizations

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Breast/Formula, Solids, Finger Foods, Cup, No Honey/ Corn Syrup

Safety: Nuts, Candy or Popcorn. Outlets, Stairs, Hot Water. Pools. Car Seats. Lead Pottery, Folk Remedies

Parenting: Child Proof Home. Drowning, Negativism, Discipline, No Shaking

Dental: Tooth Brushing/Avoid Sweets, Bottle Caries

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

PLAN

☐ Blood Lead Test

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____

Developed by County of Riverside, CHDP Program

Revised Date April 2010

Well Child Assessment - 13 to 15 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	Hgb/Hct:

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ **Walks Well**
- ☐ **Drinks well from cup**
- ☐ **Builds Tower With Two Cubes**
- ☐ **Understands Simple Commands**
- ☐ **3 Word Vocabulary**
- ☐ **Indicates Wants by pointing and grunting**
- ☐ **Waves bye-bye**

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			
Gait			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Table Food, Whole Milk/24hrs., Vitamins, Cup

Tobacco: Second-hand Smoke

Safety: Child Proof Home, Matches, Stove, Bathtubs, Teach Hot & Cold. Drowning, Leaded Pottery, Folk Remedies

Parenting: Self feeding, Simple Games, Temper Tantrum, Family Play, Delay Toilet Training, Shoes, Fever Control

Dental: Fluoride, Tooth Brushing/Avoid Sweets, Bottle Caries

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed: _____

Developed by County of Riverside, CHDP Program

Revised Date April 2010

Well Child Assessment - 16 to 23 Months

Age:	Weight:	Length:	Head Circ:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Parental Concerns:

DEVELOPMENT ☐ **Normal** ☐ **Abnormal**

☐ **Completed a standardized developmental screening tool**

PHYSICAL EXAMINATION **PM 160** ☐**Yes** ☐**No**

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Eq. Reflex			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			
Gait			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Three Meals/Day Snacks/Avoid Junk Food

Tobacco: Second-hand Smoke

Safety: Streets, Refrigerator, Freezer, Electrical Outlets, Hot Water, Drowning, Lead Pottery, Folk Remedies, Smoke Detector

Parenting: Play With Other Children, Toilet Training, Temper Tantrums, Play, Discipline, Touching Genitals, Fever Control

Dental: Fluoride, Tooth Brushing/Avoid Sweets, Bottle Caries, Importance of Primary Teeth.

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

PLAN

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed:_____

Developed by County of Riverside, CHDP Program

Revised Date April 2010

Well Child Assessment - 16 to 23 Months

Well Child Assessment - 2 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	

INTERVAL HISTORY

Diet:

Illness:

Problems:

Immunization Reaction:

Parental Concerns:

DEVELOPMENT ☐ **Normal** ☐ **Abnormal**

☐ **Completed a standardized developmental screening tool**

PHYSICAL EXAMINATION **PM 160** ☐**Yes** ☐**No**

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities			
Neurological			
Fem. Pulses			
Gait			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: 3 Meals/Family Time, Snacks, Lowfat Milk Optional, No food as reward.

Tobacco: Second-hand Smoke

Safety: Streets, Cars, Knives, Falls, Burns, Lead Poisoning.

Behavior: Runs but Falls Easily, Bumps, Rough & Tumble Play, Walks Up and Down Stairs.

Guidance: Toilet Training, Exercises, Peer Play, Accept Negativism. TV Programs

Dental: Tooth Brushing, Bottle Caries

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

BMI percentile:

PLAN

☐ Blood Lead Test

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed: _____

Developed by County of Riverside, CHDP Program

Revised Date April 2010

Well Child Assessment - 3 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	BP:

Hearing 1000	2000	3000	4000	Vision
L dB	dB	dB	dB	L R
R dB	dB	dB	dB	Both

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

☐ **Completed a standardized developmental screening tool**

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities			
Neurological			
Fem. Pulses			
Gait			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: 3 Meals/Day Snacks. Avoid Junk Food
Tobacco: Second-hand Smoke
Safety: Streets, Refrigerator, Freezer, Electrical Outlets, Hot Water. Drowning, Lead Pottery, Folk Remedies, Smoke Detector
Parenting: Play With Other Children, Toilet Training, Temper Tantrums
Dental: Routine Preventive Dental Visits, Brushing, Flossing
☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

BMI percentile:

PLAN

☐ Refer for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention/Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____

Well Child Assessment - 4 to 5 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	BP:

Hearing 1000 2000 3000 4000				Vision		Urine			
L dB	dB	dB	dB	L	R	Protein	Sugar	Blood	Other
R dB	dB	dB	dB	Both					

INTERVAL HISTORY

Diet:

Illness:

Problems:

Immunization Reaction:

Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ Gives First and Last name
- ☐ Can sing a song
- ☐ Prints few letters/numbers
- ☐ Enjoys Making Up & Telling Stories
- ☐ Walks Backward, Skips & Hops

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities			
Neurological			
Fem. Pulses			
Gait			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: 3 Meals and Snacks. Importance of Breakfast

Tobacco: Second-hand Smoke

Safety: Safety Belts, Bicycle Safety, Burns, Water Safety, Matches, Watch Outdoor Play, Swimming Lessons, Lead Poisoning

Parenting: T.V. Programs, School, Role Playing, Aggression Sexual Abuse

Dental: Preventive Dental Visits, Brushing, Flossing

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk

TB Test Given: ☐ **Yes Date** _____

Lead Risk Assessment: ☐ No Risk ☐ At Risk

ASSESSMENT

BMI percentile:

PLAN

☐ Refer for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____

Well Child Assessment - 6 to 8 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	BP:

Hearing								
1000	2000	3000	4000	Vision		Urine		
L dB	dB	dB	dB	L	R	Protein	Sugar	Blood	Other
R dB	dB	dB	dB	Both					

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Parental Concerns:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ Can Walk a Chalk Mark
- ☐ Follows Rules
- ☐ Knows Right from Left
- ☐ Rides Bicycles
- ☐ Interacts with small number of other children
- ☐ Develops self-efficacy, or the knowledge of what to do and the confidence and ability to do it.

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities			
Neurological			
Fem. Pulses			
Gait			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Junk food and Others, Exercise
Tobacco: Second-hand Smoke
Safety: Water Safety, Seat Belts, Burns, Drugs, Bicycle Helmet
Parenting: Early Sex Education, Discipline, Reading, Bed Time
Guidance: TV Programs, School
Dental: Preventive Dental Visits, Brushing, Flossing
☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk_____

ASSESSMENT

BMI percentile:

PLAN

☐ Refer for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date:_____

Signed: _____

Well Child Assessment - 9 to 12 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	BP:

Hearing 1000 2000 3000 4000				Vision		Urine			
L dB	dB	dB	dB	L	R	Protein	Sugar	Blood	Other
R dB	dB	dB	dB	Both					

INTERVAL HISTORY

Diet:
Illness:
Problems:
Sexual Activity:
Menstruation:
Parental Concerns:
Gangs:
Alcohol/Tobacco/Drugs
Emotional Health:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ School progress
- ☐ Learns new skills
- ☐ Can understand another Point of view
- ☐ Follows Rules/Understants Consequences
- ☐ Shares in household chores
- ☐ Maintains peer Relationships
- ☐ Learns from Mistakes and Failures, Tries again
- ☐ Participates in larger groups (e.g. sports team)

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back/Scoliosis			
Extremities			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: Nutrition vs. Junk Food, Read Labels. Exercise/Physical Activity
Tobacco: Health Effects, Avoid Chewing/Cigarette/Cigar Use
Safety: Seat Belt, Drowning, Helmet, Alcohol/Drugs/Tobacco Guns/Gangs
Parenting: Independence, Sex Education, Peer Pressure, Puberty
Dental: Preventive Dental Visits, Brushing, Flossing
☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk

TB Test Given: ☐ Yes Date _____

ASSESSMENT

BMI percentile:

PLAN

☐ Refer for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____

Well Child Assessment - 13 to 16 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	BP:

Hearing 1000 2000 3000 4000				Vision		Urine			
L dB	dB	dB	dB	L	R	Protein	Sugar	Blood	Other
R dB	dB	dB	dB	Both					

INTERVAL HISTORY

Diet:

Illness:

Problems:

Sexual Activity:

Menstruation:

Mental Health

Alcohol/Tobacco/Drugs

Gangs:

Parental Concerns:

Emotional Health:

☐ **Sets Goals and Works Toward Achieving Them**

☐ **Takes on New Responsibility**

☐ **Maintains Peer Relationships**

☐ **Sports**

☐ **Improved Social Skills**

☐ **Maintains family relationships**

PHYSICAL EXAMINATION

PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back/Scoliosis			
Extremities			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: 3 Meals/Nutritious Snacks, Read Food Labels

Tobacco: Health Effects, Avoid Chewing/Cigarette/Cigar Use

Safety: Seat Belt, Helmet, Guns/Gangs, Drowning

Parenting: Alcohol/Drugs, Contraception, Risk Taking Behavior
Need for Parent's Respect

Dental: Preventive Dental Visits, Brushing, Flossing

Self Care: Testicular/Breast Self Exam, Abstinence/Contraception

☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk

TB Test Given: ☐ **Yes Date** _____

ASSESSMENT

BMI percentile:

PLAN

☐ Refer for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____

Well Child Assessment - 17 to 20 Years

Age:	Weight:	Length:	Hgb/Hct:
Temp:	Pulse:	Resp:	BP:

Hearing 1000	2000	3000	4000	Vision	R	Urine			
L dB	dB	dB	dB	L		Protein	Sugar	Blood	Other
R dB	dB	dB	dB	Both					

INTERVAL HISTORY

Diet:
Illness:
Problems:
Sexual Activity:
Menstruation:
Mental Health
Alcohol/Tobacco/Drugs
Gangs:
Parental Concerns:
Emotional Health:

DEVELOPMENT ☐ Normal ☐ Abnormal

- ☐ Acts Responsibly for Self
- ☐ Maintains School Achievement
- ☐ Maintain Family Relationships
- ☐ Improved Social Skills
- ☐ Exhibits Capacity for Empathy, Reciprocity in Interpersonal Relationships
- ☐ Job/Future Plans
- ☐ Takes on new responsibilities

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	Ab	Abnormalities/Comments
General Appearance			
Nutrition			
Skin/Acne			
Head, Neck & Nodes			
Eyes/Vision			
ENT/Hearing			
Mouth/Dental			
Chest/Lungs			
Heart			
Abdomen			
Ext. Genitalia			
Back/Scoliosis			
Extremities			
Neurological			
Femoral Pulses			

EDUCATION (Circle Items Discussed with Patient/Family)

Nutrition: 3 Meals/Nutritious Snacks.
Tobacco/Drugs/Alcohol: Health Effects
Safety: Seat Belt, Helmet, Risk Taking Behavior
Dental: Preventive Dental Visits, Brushing, Flossing
Self Care: Self Testicular/Breast Exam, Adequate Exercise, Abstinence/Contraception
☐ **Growing Up Healthy:** Brochure Given

TB Risk Assessment: ☐ No Risk ☐ Risk

ASSESSMENT

BMI percentile:

PLAN

☐ Refer for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT:

1. Patient is exposed to Passive (Second-hand) Tobacco Smoke. Y ☐ N ☐
2. Tobacco Used By Patient. Y ☐ N ☐
3. Counseled About/Referred For Tobacco Use Prevention Cessation Y ☐ N ☐

Patient ID:

Exam Date: _____

Signed: _____