

## Comprehensive Health Assessment

<b>13 to 16 Years Old</b>	Actual Age: _____	Date: _____
Medical Record #		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other:	
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Interpreter Name: _____	
<b>Intake</b>	<b>Vital Signs</b>	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
BMI %		
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Hearing Screening	<input type="checkbox"/> Responded at $\leq 25$ dB at 1000-8000 frequencies in both ears <input type="checkbox"/> Non coop	
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
<b>Interval History</b>		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active ( $\geq 60$ min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain	
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See <a href="#">CAIR</a>	
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other:	
LMP (females):	<input type="checkbox"/> Menorrhagia	
<b>Current Alcohol / Substance use</b>	<input type="checkbox"/> None <input type="checkbox"/> Alcohol	
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
<b>Family History</b>	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other:		

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Psychosocial & Behavioral Assessment, Family/ Social Factors	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)		
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____		
<b>AAP Risk Screener</b>	<b>Screening Tools Used</b>	<b>Low Risk</b>	<b>High Risk</b> (see Plan/ Orders/AG)
Alcohol Misuse	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> <a href="#">CRAFFT</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/> <a href="#">PHQ-9A</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> <a href="#">CRAFFT</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> <a href="#">PEARLS</a> , <input type="checkbox"/> <a href="#">PEARLS-12&amp;UP</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> <a href="#">PSC</a> , <input type="checkbox"/> <a href="#">PSC-Y</a> , <input type="checkbox"/> <a href="#">HEADSSS</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Cardiac Arrest	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/> <a href="#">ASQ</a> , <input type="checkbox"/> <a href="#">PHQ-9A</a> , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> <a href="#">TB Risk Assessment</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Growth and Development / School Progress</b>			
<input type="checkbox"/> School achievement	<input type="checkbox"/> Performs chores	<input type="checkbox"/> Plays / listens to music	
<input type="checkbox"/> School attendance	<input type="checkbox"/> Learns new skills	<input type="checkbox"/> Reads	
<input type="checkbox"/> Understands parental limits & consequences for unacceptable behavior	<input type="checkbox"/> Participates in organized sports / social activities	<input type="checkbox"/> Uses both hands independently	
<input type="checkbox"/> Ability to get along with peers	<input type="checkbox"/> Learns from mistakes & failures, tries again	<input type="checkbox"/> Preoccupation with rapid body changes	
<b>Physical Examination</b>			<b>WNL</b>
General appearance	Well-nourished & developed No abuse/neglect evident		<input type="checkbox"/>
Head	No lesions		<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal		<input type="checkbox"/>
Ears	Canals clear, TMs normal Hearing grossly normal		<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions		<input type="checkbox"/>
Teeth	No visible cavities, grossly normal		<input type="checkbox"/>

# Comprehensive Health Assessment

Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest/Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal Tanner stage: I II III IV V	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
<b>Subjective / Objective</b>		
<b>Assessment</b>		
<b>Plan</b>		
<b>Referrals</b>		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> OB/GYN:	<input type="checkbox"/> Other:	
<b>Orders</b>		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Tdap	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> HIV	<input type="checkbox"/> CXR
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Herpes	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> ECG
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:		

Name:

DOB:

<b>Anticipatory Guidance (AG) / Education (✓ if discussed)</b>		
<b>Diet, Nutrition &amp; Exercise</b>		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
<b>Accident Prevention &amp; Guidance</b>		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Social Media Use	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Academic or work plans
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Motor vehicle safety (no texting & driving)	<input type="checkbox"/> Physical growth
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Sexuality
<b>Tobacco Cessation</b> Quit Date:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
<b>Next Appointment</b>		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

<b>Documentation Reminders</b>		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

<b>MA / Nurse Signature</b>	<b>Title</b>	<b>Date</b>
<b>Provider Signature</b>	<b>Title</b>	<b>Date</b>

<b>Notes (include date, time, signature, and title on all entries)</b>