Ages 10-13 Year Health Survey (2 SIDES)

Child's Name____

Allergies?____________________________________

Meds?______________________________________

Vitamins?____________________________________

Family:
Have there been any significant change in your family life this year? (i.e. move, divorce, illness, etc)

No

Yes___________________________________

General health:
Are there any health issues you would like to discuss today? Please pick the **2 most important** you would like covered:

____

Education:
Child's school/grade___________________________
Any concerns?

No

Yes___________________________________

Any difficulty in classes or failing any subjects?

No

Yes___________________________________

Any trouble completing homework or other assignments:

No

Yes___________________________________

Any difficulty with teachers, friends, peers:

No

Yes___________________________________

Electronics & Media:
How many hours of non-school related computer/TV/video on a TYPICAL day?___________

Activities:
What physical activities does your child participate in and how often? (i.e. soccer/dance)

What other organized activities does your child participate in and how often? (i.e. art/music)

Safety:
Does your child wear a seatbelt when riding in a vehicle?

Yes

No

Sometimes

Does your child wear a helmet for biking, skiing, skating, scootering, ATVing, motorbiking?

Yes

No

Sometimes

Not applicable

Are there any **guns** in your home?

No

YES- safely stored via:

____

Do you own any animals/pets?

No

Yes, __________________________________

Sleep:
Any concerns?________________________________

How many hours on a TYPICAL night?____________

***PLEASE COMPLETE THE SECOND SIDE →**

Bowel Movements:
Any concerns?______________________________

How many BMs on a typical day?______________

Are their BMs LOOSE/SOFT/HARD/PAINFUL? (circle)

Nutrition:
Is your child on a modified diet (i.e. vegan, vegetarian, gluten or dairy free)?

No
Yes, ________________________________

Do you have any **concerns** about your child's diet?

No
Yes, ________________________________

Does your child have any concerns about their physical appearance?

No
Yes, ________________________________

On a **typical** day, how many servings does your child get of:

Fruit (serving = 1 tennis ball) __________________

Vegetable (serving = ½ baseball cooked, 1 baseball fresh)
____

Dairy (serv = 1 cup milk/yogurt, 1.5 oz cheese) ____

Fish/Egg/Red Meat or Poultry:
(2-3 oz meat/fish/chicken/tofu, ½ cup beans,
2 tbsp nut butter, 1-2 eggs)

____

Dental:
Any dental concerns?

NO
YES_________________________________

Does your child see the dentist twice yearly?

NO (last seen________________________)
YES

Menstrual History (only answer if applicable)
Have you started your period? If yes, when:

No
Yes, ________________________________

Is your period approximately every 4 weeks?

No _________________________________
Yes

Do you have cramps with your period?
(if yes, do you take medication and which):

No
Yes, ________________________________

Do you have any other symptoms with your period?
(i.e. nausea, vomiting, headaches, mood swings)

No
Yes, ________________________________