

WELL CHILD EXAM-Early Adolescence: 11 - 14 Year

DATE

PATIENT NAME			DOB		SEX		PARENT NAME			
Allergies					Current Medications					
Prenatal/Family History of Illness and Disease					Chief Complaint(s)					
Weight	Percentile	Length	Percentile	BMI	Percentile	Temp.	Pulse	Resp.	BP	
	%		%		%					

Interval History: (Include injury/illness, visits to other health care providers, changes in family or home)

Nutrition

☐ Grains _____ servings per day

☐ Fruit/Vegetables _____ servings per day

☐ Whole Milk _____ servings per day

☐ Meat/Beans _____ servings per day

☐ City water ☐ Well water ☐ Bottled water

Elimination ☐ Normal ☐ Abnormal

Exercise Assessment

Physical Activity: _____ minutes per day

Sleep ☐ Normal ☐ Abnormal

Reproductive

Menstrual

☐ Premenarchal ☐ Normal ☐ Abnormal

Breast Exam/Palpation

☐ Normal ☐ Abnormal

Sexual Activity ☐ Yes ☐ No

Contraceptive Method used _____

Additional area for comments on page 2

Screening and Procedures:

Hearing ☐ Screening audiometry

☐ Parental observation/concerns

Vision ☐ Visual acuity

____R ____L ____Both

☐ Parental observation/concerns

Dental ☐ Oral Health Risk Assessment

Developmental Surveillance

☐ Social-Emotional ☐ Communicative

☐ Cognitive ☐ Physical Development

Psychosocial/Behavioral Assessment

☐ Y ☐ N

Screening for Abuse ☐ Y ☐ N

If Risk:

☐ IPPD _____ (result)

☐ Hct or Hgb _____ (result)

☐ Dyslipidemia _____ (result)

☐ STI Screening _____ (result)

☐ Cervical Dysplasia _____ (result)

☐ Sickle Cell (if not previously tested) _____ (result)

Immunizations:

☐ Immunizations Reviewed, Given & Charted (according to AAP.org guidelines) *If needed but not given, document rationale*

☐ Impactsiis (OH registry) updated

Patient Unclothed ☐ Y ☐ N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

☐ Normal Growth and Development

☐ Tanner Stage _____

Alcohol & Drug Use (risk assessment)

☐ Y ☐ N

☐ Abnormal Findings and Comments

(see additional note area on next page)

Results of visit discussed with child/parent

☐ Y ☐ N

Plan

☐ History/Problem List/Meds Updated

☐ Referrals ☐ Transportation

☐ Children Special Health Care Needs

☐ Dental ☐ Other _____

Anticipatory Guidance/Health Education
(√ if discussed)

Safety

☐ Avoid alcohol, tobacco, drugs, inhalants

☐ Make a plan with child if in unsafe situation

☐ Seat belt use

☐ Swimming/Water Safety

☐ Use bike helmet/protective sporting gear

☐ Gun and weapon safety

Nutrition/physical activity

☐ Limit sugar and high fat food/drinks

☐ Healthy weight

☐ Offer variety of healthy foods and include 5 servings of fruits & veggies every day

☐ Limit TV, video, and computer games

☐ Physical activity & adequate sleep

☐ Eat meals as a family

Oral Health

☐ Schedule dental appointment

☐ Brush and floss teeth

☐ Limit sweets/soda

Child Development and Behavior

☐ Discuss puberty, development, contraception, STDs

☐ Normal sexual feelings/delaying sex

☐ Peer relationships

☐ Discuss family & household responsibilities

☐ Discuss ways to handle anger/conflict

☐ How to handle stress & disappointment

Family Support and Relationships

☐ Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression

☐ Know child's friends and their families

☐ Spend family time together

☐ Encourage positive interaction with siblings, teachers, friends and you

☐ Discuss limits and consequences

☐ Home, school, community rules

☐ Discuss school transitions & ability to adapt

☐ Encourage participation with peer activities

☐ Encourage to volunteer/participate with religious, school or community activities

Next Well Check: _____ years of age

Developmental Questions and Observations on Page 2

Provider Signature: _____

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Developmental Questions and Observations

You may use the following screening list, or an age appropriate standardized developmental instrument or screening tool.*

Ask the parent to respond to the following statements about the child:

Yes No

☐ ☐ Please tell me any concerns about the way your child is behaving or developing

☐ ☐ My child eats breakfast everyday.

☐ ☐ My child is doing well in school.

☐ ☐ My child has one or more close friends.

☐ ☐ My child handles stress, anger, frustration well, most of the time.

☐ ☐ My child seems rested when he/she awakens.

☐ ☐ My child enjoys at least one activity and/or interest.

☐ ☐ My child joins in family activities.

☐ ☐ My child's activities are supervised by adults I trust.

Ask the parent to respond to the following statements:

☐ ☐ I am proud of my child.

☐ ☐ I talk to my child about alcohol, drugs, smoking and sex.

Ask the child to respond to the following statements:

Yes No

☐ ☐ I feel good about my friends and school.

☐ ☐ I know what to do when I feel angry, stressed or frustrated.

☐ ☐ I enjoy school

*Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

Your Child's Health at 11 - 14 Years

Milestones

Ways your child is developing between 11 and 14 years of age.

- Most children get their second molars (back teeth) between 12 and 13. Talk with your dentist about sealants. Your child should floss daily.
- Between the ages of 10 and 14 many girls will begin to grow breasts and pubic hair and begin their periods.
- Between 10 and 14 many boys will begin to grow pubic hair and they may notice their scrotum and penis begin to change. Their voice may change and they may start to grow facial hair.
- Many boys and girls will have a growth spurt sometime between 10 and 15.
- Your child may have a hard time making good choices and may feel pushed to make bad choices so they feel like they fit in with kids at school.

For Help or More Information:

Social Support Services: Contact the local county Department of Job and Family Services Healthchek Coordinator

Firearm safety:

Call 1-202-662-0600 or go to www.safekids.org

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at www.ndvh.org

Child sexual abuse, physical abuse, information and support:

- Rape, Abuse, and Incest National Network at 1-800-656-HOPE (4673)
- State of Ohio Child Protection: 866-635-3748
- Childhelp National Child Abuse Hotline 1-800-4-A-CHILD (1-800-422-4453) or online at www.childhelp.org

Information for teens and their parents:

Provides information for teens and parents of teen on many teen topics. <http://www.kidshealth.org/>

Sexuality Information for teens:

(Planned Parenthood® Federation of America)
www.teenwire.com

Children's Mental Health parent support and advocacy:

Contact Ohio Department of Mental Health
-877-275-6364

Churches or schools in your area may give classes on how to handle conflicts and/or anger. These can be useful skills for young teenagers.

Health Tips:

Growth happens at different times for everyone. This can worry a child. If your child has not begun to have growth changes by age 14 talk with the doctor.

Your child will need shots at this age. Talk with your child's doctor and make sure your child has had all of her shots.

Your child should have a goal to be physically active at least 60 minutes each day. It doesn't have to be all at once. Find activities that you and your child enjoy. This is an important habit for your child to learn.

It is important that your child eat healthy foods and snacks. Keep healthy snacks available. Your child needs fruit, vegetables, juice, and whole grains for growth and energy.

Parenting Tips:

Talk with your child about the changes in her body before and as the changes happen. Tell her these are signs of growing up and it can be exciting but can also be scary.

Your child may be more emotional and sometimes rude or angry. Sometimes he feels sad, nervous or worried and things may not be going right. Talk with your child about his feelings. Help him find a counselor if needed.

Talk with and let your child know that sexual feelings are normal, but to delay having sex.

Your child is growing mentally. You can help her thinking skills by asking her to solve problems.

Talk about why teenagers should not use drugs and alcohol. Set a good example for your child.

Teach your child how to deal with peer pressure.

Encourage your child to join school or sporting activities.

Safety Tips

Cigarettes, drugs and alcohol are often offered to teenagers. Practice "saying no" with your child.

Teach your child gun safety. If you keep guns or rifles in your home, make sure they are unloaded and locked up.

Teach your child to walk away if they see someone with a gun or other weapon and then report it to an adult they trust.

Teach your child to always wear a seatbelt in the car and to sit in the back seat until they are adult height and weight.

It's important for your child to use the correct sports equipment and safety gear. Make sure it fits your child well.