



Well Child Check: School Aged Child (13-14 years)

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

Do you have any concerns, questions, or problems that you would like to discuss today? If yes, please describe:

\_\_\_\_\_

Current grade/name of school \_\_\_\_\_

Nutrition:

Do you get 4 servings of dairy a day?  Yes  No

What milk do you drink? \_\_\_\_\_

Does your diet include iron-rich foods daily (meat, beans, enriched cereals/cheerios)?  Yes  No

Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?  No  Yes

If you are a vegetarian, do you take an iron supplement?  Yes  No

Females:

If you have started your menstrual cycle, do you think you have excessive menstrual bleeding?  No  Yes  N/A

Dental Health:

Do you brush your teeth 2x per day?  Yes  No

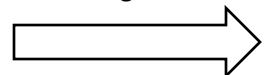
CARDIOVASCULAR SCREEN:

Table with 3 columns: Question, No, Yes. Rows include: Have you ever fainted while exercising?, Do you typically cough or have shortness of breath when exercising? Outside of deconditioning?, Have you gotten aching chest pain when you exercise?, Has anyone in your family had a heart attack or stroke before age 55?, Did anyone in the family die suddenly while exercising?

MENTAL HEALTH SCREEN (PHQ-2)

In the past two weeks, how often have you been bothered by the following symptoms:

- 1. Feeling down, depressed, irritable, or hopeless? Not at all, Several Days, More than half of the time, Nearly every day
2. Little interest or pleasure in doing things? Not at all, Several Days, More than half of the time, Nearly every day



Who lives with you at home? \_\_\_\_\_  
Are parents:     single                    married                    divorced                    separated  
What things do you like to do?

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- Are you doing well at school?  Yes  No
- Do you have things you enjoy doing at school?  Yes  No  
Do you get extra help or support in any subjects at school?  No  Yes
- Do you have any concerns about your weight?  No  Yes  
Are you currently doing anything to try to gain or lose weight?  No  Yes  
Do you eat fruit and vegetables every day?  Yes  No  
Do you drink sugar sweetened beverages (juice, soda, sports drinks)?  No  Yes  
Do you ever skip meals?  No  Yes  
Do you eat meals together with your family?  Yes  No  
Are you physically active at least 1 hour a day?  Yes  No  
How much time everyday do you spend watching TV, playing video games, or using computers, tablets or smartphones (not counting schoolwork)? \_\_\_\_\_  
Do you get 8 or more hours of sleep each night?  Yes  No  
Do you have trouble sleeping?  No  Yes

Females: Do you have any concerns about your period (such as not regular, heavy bleeding or bad cramping)?

- No  Yes
- Do you smoke cigarettes, vape, chew tobacco?  No  Yes  
Does anyone in your home smoke or vape?  No  Yes  
Do you drink alcohol?  No  Yes  
Have you ever used drugs (including marijuana or street drugs)?  No  Yes
- Do you spend time talking with your parents every day?  Yes  No  
Do you get along with your family?  Yes  No  
Does your family do things together?  Yes  No  
Do you have an adult you feel connected to?  Yes  No  
Do you have rules at home and know what happens when you break the rules?  Yes  No
- Have you ever taken prescription drugs that were not given to you for a medical condition?  No  Yes  
Do you always wear a lap and shoulder seat belt?  Yes  No  
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?  Yes  No  
Do you use sunscreen?  Yes  No
- Do you visit tanning parlors?  No  Yes  
Do you have activities or things you like to do after school or on the weekend?  Yes  No
- Do you feel safe at home?  Yes  No  
Have you ever been bullied in person, on the internet, or through social media?  No  Yes  
Have you been in a relationship with a person who threatened you physically or hurt you?  No  Yes  
Have you ever been forced or pressured to do something sexually that you didn't want to do?  No  Yes