



CHILD/ADOLESCENT INFORMATION

We need this information to help take care of you. It will be held in confidence as long as it not life threatening.

Name _____ Date _____

Date of Birth _____ Age _____ Grade _____ School _____

What are your symptoms, concerns or struggles? _____

How long have you had these concerns? _____

Have there been any significant changes in your family life?

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Divorce | <input type="checkbox"/> New job | <input type="checkbox"/> Death, who _____ |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Moved to new home | <input type="checkbox"/> Birth, who _____ |
| <input type="checkbox"/> Loss of job | <input type="checkbox"/> Moved to new school | Other _____ |

Do you smoke? _____ Yes _____ No If yes, how much? _____ Cigarettes/day

Do you drink alcohol? _____ Yes _____ No If yes, how much? _____ Drinks/week

Do you use any other substance(s)? _____ Yes _____ No

If yes, what and how much? _____

Are you sexually active? _____ Yes _____ No

If yes, do you use contraception? _____ Yes _____ No

How are things at school?

- | | |
|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Great | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Good | <input type="checkbox"/> Not so good |

If "not so good", why? _____

How do you get along with your friends?

- Great
- Good
- Fair
- Not so good

If "not so good", why? _____

How do you get along with your parents?

- Good
- Great
- Fair
- Not so good

If "not so good", why? _____

Anything else you would like us to know to help in your care? _____

Nutrition Assessment

Please check any food/fluid/weight struggles that you are currently experiencing:

- Calorie restriction
- Excessive exercise
- Body image distress
- Binge eating
- Compulsive exercise
- Significant weight changes
- Dieting
- Diet pills
- Frequently weighing self
- Rigid food rules/rituals
- Laxatives (abuse)
- Low weight
- Lack of food variety
- Diuretics (abuse)
- Overweight
- Chewing and spitting
- Purging (vomiting)
- Constipation
- Fluid restriction
- Regurgitation
- Diarrhea
- Fluid loading
- Hiding food
- Reflux
- Excessive caffeine intake
- Calorie counting
- Involuntary vomiting
- Excessive alcohol intake
- Other: _____
- Other: _____

Describe in further detail any concerns circled above (frequency, volume, etc _____

To the best of your ability, please write what a typical day of food consumption looks like for you during the week and weekend. Include eating times and places, with whom, beverages and condiments consumed, and exercise (if applicable).

Weekday

Weekend

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Patient Signature _____ Date _____

PAIN ASSESSMENT FORM

Do you have pain? <p style="text-align: center;">Yes or No</p>	If “Yes” , please answer the follow pain questions . . .										
Where is your pain located?											
What type of pain?											
How much does your pain hurt? (What is your pain intensity?) <p style="text-align: center;"><i>(Please circle number)</i></p>	No hurt	Hurts a little <i>(Mild & annoying)</i>		Hurts more than a little <i>(Nagging, uncomfortable, troublesome)</i>		Hurts even more <i>(Miserable, distressing)</i>		Hurts a whole lot <i>(Intense, dreadful, horrible)</i>		Hurts Worse <i>(Worst pain possible, unbearable)</i>	
	0	1	2	3	4	5	6	7	8	9	10
How long have you had this pain?											
What causes you to have pain or for the pain to increase?											
How does your pain affect your functioning or quality of life? <p style="text-align: center;"><i>(Please circle number)</i></p>		Does not limit activities		Can do most activities with rest period		Unable to do some activities		Unable to do most activities		Unable to do any activities	
	0	1	2	3	4	5	6	7	8	9	10
Do you get treatment for your pain? <p style="text-align: center;">Yes or No</p>											
What is your pain treatment and who prescribes it?											
How much relief do you get from your pain treatment? <p style="text-align: center;"><i>(Please circle number)</i></p>	No Relief 1		Mild Relief 2		Moderate Relief 3		Complete Relief 4				