

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse: Resp:
Allergies:			Weight:		Height:
			lb / kg	%	cm
Vision Chart Exam:		Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Perform
Hearing Screening:		Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How do you feel about your child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Twice Daily Brushing/Flossing (With Parent Assistance) Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise (1hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Uses Imaginary Characters Matches Colors and Shapes/Prints Some Numbers and Letters
 Counts to 10 Follows Simple Directions Listens and Attends Can Button & Zip Clothing Independently
 Goes to Bathroom Independently Holds Pencil/Cuts with Scissors Cooperates More in Group Setting
 Good Articulation/Language Skills Hops/Skips Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Booster Seat) Safety at Home Sun Safety Sports/Helmet Use Bullying Good and Bad Touches
 TV Screen Time Begins to Agree with Rules Dictates Story to Adults Listens to Authority Figure & Follows Instructions
 School Readiness Communication with Teachers Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Self-Calming Wants to Please & Be with Friends Shows Empathy for Others Positive about Self & Abilities
 Tells Stories of Convenience (Lying) Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: Blood Lead Testing (Child at Risk/Not Already Done at 12/24Months) TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV Influenza Had Chicken Pox
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental Head Start OT PT Speech WIC
 Specialist: Developmental Behavioral Other _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No