

CHILD HEALTH CHECK 9-14 years



Practice name _____

First name _____ Surname _____

Date of Birth: _____

Name of parent or primary carer:	
Address:	
Suburb:	
State:	Postcode:
Phone: (H)	
Mobile:	
Medicare number:	

Indigenous status: Aboriginal Torres Strait Islander Both Neither Other

Has child had a Health Check (708) in the past 12 months. Yes No

The process and benefits of a health check have been explained and consent has been given to proceed. Yes No

Doctors name: _____ Practice address: _____

Phone: Business hours: _____

After Hours emergency: _____

BACKGROUND INFORMATION

Current Health: Parent/child says current health is _____

Personal Medical History:
(hospitalisations, serious illness, etc) _____

Family Medical History:
Diabetes Yes No **Heart disease** Yes No
Other family medical history: _____

Social History: _____

Immunisation status up to date?

Yes No

Comment:.....
.....

Ring ACIR 1800 653 809.
You will require parental consent, Medicare number and GP provider number.

Any known allergies? Yes No If yes, list: _____

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PHYSICAL EXAMINATION

Height: _____ cm Percentile for Height: _____
Weight: _____ kgs Percentile for Weight: _____ Comment: _____

Hearing

In the past 12 months have you had ear infections? Yes No

Is anyone concerned about your hearing? Yes No

If yes, describe _____

Right Ear (otoscope) Normal Red Retracted Perforated Discharge

Left Ear (otoscope) Normal Red Retracted Perforated Discharge

Eyes

Visual acuity : Right eye /6 Left eye /6 Glasses? Yes No

Sclera, eyelids, eyelashes: Healthy Other: _____

Chest auscultation:

Pulse: _____ Regular Yes No

Does child take any medications regularly? Yes No If yes, list: _____

Skin Integrity Healthy Sores / Bites Scars / Bruises Rash
 Itchy Other _____

Limbs Healthy Swollen joints Sore joint(s) Other: _____

Movement Healthy Abnormal gait: _____

Head and Face Healthy Facial Anomalies: _____

Anaemia? (check palms, conjunctiva of eyes, tongue): Healthy Pale

Comments _____

Development and Education: (milestones):

Which school do you go to? _____ Year _____

Are you having any trouble with learning? Yes No

Do you have any trouble making new friends? Yes No

Mood - In the last month have you felt.....

So sad nothing could make you happy? Yes No

So worried that you felt sick in the belly? Yes No

Any parental concerns? Yes No

If yes to any questions above, please explain: _____

Sexual Health and Development

- Key topics: physical changes, hygiene, risks and consequences of sexual experimentation, pregnancy, STI's.

Has the child started puberty? Yes No

Does the child understand what's happening? Yes No

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LIFESTYLE

Oral Health

Access to toothbrush and toothpaste?

Yes No

Every person needs their own personal toothbrush. This should be regularly replaced.

Frequency of brushing?

1-2 x day
 Sometimes
 Never

Teeth should be brushed twice a day: once in the morning and before bed at night

Do you use dental floss?

Yes No

Teeth should be flossed daily to prevent tooth decay in "hard to clean" places.

Have you been to the dentist in past 12 months?

Yes No

Regular visits to dentist help keep teeth clean and decay free.

On examination -

Normal
 Erupting teeth
 Decay

Smoking and drinking

Does anyone smoke or drink in your house?

Yes No

Discussed importance of protecting children from smoke and alcohol.

Do you smoke or drink?

Yes No

Discussed risks associated with smoking and drinking

Exercise

Do you play outside and exercise up to one hour per day?

Yes No

Recommend age appropriate activities.

Sun protection

Do you wear a hat and sunscreen when playing outside?

Yes No

Recommend SPF 30 sunscreen and a hat for outside activities.

Sleep

How many hours sleep do you get in total each day? _____

9 - 11 hours is recommended at this age.

Nutrition

Do you regularly eat breakfast, lunch and dinner?

Yes No

Recommend healthy diet including fruit, vegetables, dairy, protein from meat, chicken or fish and high fibre.

How often do you eat take-away food?

every day
 3 x week
 not often

Take away food is high in fats and not very nutritious. Limit take-away food.

How often do you drink juice, cordial or soft drink?

Every day
 Sometimes
 Not often

Recommend limiting sugar drinks to special occasions and provide water to drink instead.

Topics initiated by parent

Are there any topics the parent or carer would like to talk about? Yes No
If yes, describe _____

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CLIENT SUMMARY

Risks identified:

- 1.
- 2.
- 3.

STRATEGY FOR GOOD HEALTH

Visit GP every year for health check.
Follow dietary and exercise advice as discussed.
Brush teeth twice a day and floss.
Protect self from smoke and alcohol.
Wear sunscreen and a hat outside.
Attend appointments as arranged.

PERSONAL GOAL

_____ has identified the most important risk to work on
as: _____
and plans to _____

APPOINTMENTS / TESTS

List required appointments or tests here:

Arrangements made? Yes No

Arrangements made? Yes No

Dr _____ has discussed a strategy for improving my child's health based on the risk factors identified. Follow up appointments and any additional tests required have been explained to me.

Assisted by: _____ RN / AHW / _____

Completed by: Dr _____

Date completed: _____

Copy of the Health Strategy offered to the parent / child? Yes No

Review date: _____ (minimum 12 months) Medicare item # 708