

**UNITED HOSPITAL CENTER  
Family Medicine  
Patient Self-Reporting Intake Assessment**

Pediatric Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please answer the following questions as appropriate:

**NUTRITIONAL INFORMATION**

|  | Yes                      | No                       | N/A                      | Comments |
|--|--------------------------|--------------------------|--------------------------|----------|
| If the child is breast feeding are there any problems?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| If the child is taking formula is there any excessive "spitting up"?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| How would you describe the child's appetite as: ( <i>Circle one</i> )  | <b>Good</b>              | <b>Bad</b>               |                          | _____    |
| Have you noticed the child gaining or losing weight in the past month? | <input type="checkbox"/> | <input type="checkbox"/> | <b>Unsure</b>            | _____    |

**FUNCTIONAL INFORMATION**

|  |                          |                          |                          |       |
|--|--------------------------|--------------------------|--------------------------|-------|
| Is the child having any difficulties performing physical activities for his/her age?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| If the child is of school age are there any problems with school activities, (Reading, writing, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**PATIENT SAFETY**

|  |                          |                          |               |       |
|--|--------------------------|--------------------------|---------------|-------|
| Do you feel the child has a safe home environment? | <input type="checkbox"/> | <input type="checkbox"/> | <b>Unsure</b> | _____ |
|--|--------------------------|--------------------------|---------------|-------|

**COMMUNICATION**

Please mark any problems below that may cause difficulty for you or your child to understand the plan of care:  
 Vision ( ) Hearing ( ) Reading ( ) Language ( )  
 Other ( ) please list:

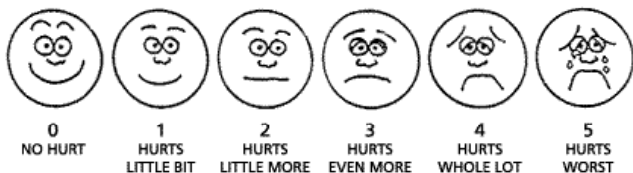
**PAIN ASSESSMENT**

|                                     |                          |                          |               |       |
|-------------------------------------|--------------------------|--------------------------|---------------|-------|
| Is the child currently having pain? | <input type="checkbox"/> | <input type="checkbox"/> | <b>Unsure</b> | _____ |
|-------------------------------------|--------------------------|--------------------------|---------------|-------|

If unsure of pain in the child use the scale below

Mark the scale below for pain as it relates to the child's behavior or use the "faces" to have the child help in rating his/her pain (ask for help if needed)

- 1 = Facial wrinkling, tightly closed or wide open eyes, blinking, grimacing
- 2= Crying, Moaning
- 3= Aggression-hitting, biting
- 4= Increase in body movement
- 5= Guarding of a body part
- 6= Decrease in social interaction or common routines
- 7= Increased rest periods
- 8= Irritability



Reviewed by Physician and discussed with patient