Date of Service: _____ Acct #: _____
Patient Name: _____ DOB: _____

Medical Screening Questionnaire

Does your child have a sibling or playmate that has had lead poisoning?	YES	NO	UNSURE
Does your child live in or regularly visit a house or childcare facility built before 1978 that has been renovated in the last 6 months? Do you live in or visit a home or facility built before 1950?	YES	NO	UNSURE
Does your child chew on or eat non-food items like paint chips or dirt?	YES	NO	UNSURE
Was your child born in a country or traveled for longer than a week to a country at high risk for tuberculosis? Is there a family member or close contact with TB or had a positive TB test?	YES	NO	UNSURE
Is your child infected with HIV or have any conditions that lower the immune system?	YES	NO	UNSURE
Has your child been exposed to anyone who is in jail, has HIV, is homeless, or uses illegal drugs?	YES	NO	UNSURE
Has a doctor ever ordered a test for your child's heart or does your child see a Cardiologist?	YES	NO	UNSURE
Has your child ever had discomfort, pain, or pressure in his chest during exercise?	YES	NO	UNSURE
Has your child ever had extreme shortness of breath, or extreme fatigue during exercise (different from other children)?	YES	NO	UNSURE
Has your child fainted or passed out, or had a seizure DURING or AFTER exercise, emotion, or startle?	YES	NO	UNSURE
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (Including SIDS, car accident, drowning, others) or near drowning? If yes, what? _____	YES	NO	UNSURE
Does your child have a parent or sibling with the following conditions? Hypertrophic cardiomyopathy, long or short QT syndrome, Marfans or Loeys-Dietz, Arrhythmogenic right ventricular cardiomyopathy, Brugada syndrome, Catecholaminergic polymorphic ventricular tachycardia	YES	NO	UNSURE
Anyone younger than 50 years old with a pacemaker or implantable defibrillator?	YES	NO	UNSURE
Do you have any concerns about how your child sees?	YES	NO	UNSURE
Do you have any concerns about how your child hears?	YES	NO	UNSURE
Do you have any concerns about your child's speech?	YES	NO	UNSURE
Does anyone in your household smoke?	YES	NO	UNSURE
Do you have city or well water?	CITY		WELL
Does your child have a dentist? If yes, have they been seen in the last 6 months?	YES	NO	

For Patients 11 years and older

Do you wear a seat belt all the time? YES NO
Are you or have you ever been sexually active? YES NO

Do you or have you ever ridden in a car driven by someone who was using drugs or alcohol? YES NO
Do you or have you ever smoked cigarettes (regular or electronic)/VAPE/JUUL? YES NO
Do you or have you ever used any kind of drugs including synthetic marijuana (spice, K2) or alcohol? YES NO
Have you ever gotten into trouble while using drugs or alcohol? YES NO
Do you use anything else to get high (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? YES NO

PLEASE ANSWER THE QUESTIONS ON THE BACK IF YOU ARE 11 YEARS OR OLDER.

Date: _____ **Acct #:** _____

Patient Name(s): _____ **DOB:** _____

PEDIATRIC ASSOCIATES

The services listed below may be provided by Pediatric Associates and may not be covered by your insurance carrier. I understand that **I will be responsible for the services rendered**. This includes but is not limited to Hearing and Vision Screenings, Fluoride Varnish, Ages & Stages, and Vanderbilt forms.

We are unable to verify coverage on all patients: therefore, it is your responsibility to check with your insurance carrier to determine if the services are covered.

IMMUNIZATIONS:

1. _____ I have **NO** insurance to pay for immunizations (includes: Medi-share, Liberty Aliera, Unity, OneShare, Solidarity, Christian Health Ministries, and Samaritan)
2. _____ I have Medicaid/Peachcare/Amerigroup/Peachstate/Caresource
3. _____ My insurance pays for immunizations
4. _____ My insurance does **NOT** cover preventative services
5. _____ I request a copy of an updated 3231 Immunization Form

* You will be provided with an information packet regarding immunizations administered today. *

Please be aware that we are now required to do hearing and vision screens at the ages of 3, 4, 5, 6, 8, 10, 15 and 18yrs. **Your insurance carrier may or may not cover the hearing and/or vision screen. Please be aware that you will be responsible for the $20.00 charge for the hearing screen and $20.00 for the vision screen if it is not a covered service.**

There will be a $10.00 charge for Fluoride Varnish if it is not a covered service. This will be performed at 9mos, 15mos, 24mos, 30mos, and 36mos.

I hereby give consent for immunizations to be administered to my child today and/or have the hearing and/or vision screening and/or Fluoride Varnish completed.

_____ I decline to have the Hearing and/or Vision screen completed at this time.

_____ I decline to have the Fluoride Varnish completed at this time.

Parent/Guardian Signature: _____

Witness: _____

Children's Healthcare of Atlanta

STRONG4LIFE

NAME: DATE:

Healthy Habits Assessment (Adolescent)

Circle the answer that best describes your usual eating and activity habits.

I eat veggies: (a serving is about the size of your fist)

0-1 serving a day	1-2 servings a day	3-4 servings a day	More than 4 servings a day

I eat fruits: (a serving is about the size of your fist)

0-1 serving a day	1-2 servings a day	3-4 servings a day	More than 4 servings a day

I eat out:

More than 4 times a week	3-4 times a week	1-2 times a week	0-1 times a week

I am active:

Not very often	Less than 30 minutes a day	30-60 minutes a day	More than 60 minutes a day

I have sweet drinks (soda, sweet tea, 100% fruit juice, sports drinks, other fruit drinks):

More than 3 cups a day	2 cups a day	1 cup a day	Not very often

I watch television, play video games, spend (non-school-related) time on the computer, tablet or cell phone:

More than 2 hours a day	1-2 hours a day	30-60 minutes a day	Not very often

Most nights, I sleep:

Less than 7 hours	7-8 hours	9-10 hours	More than 10 hours

If you could work on one healthy habit, which would it be?

- ❍ Make half your plate veggies and fruits
- ❍ Limit screen time
- ❍ Be more active
- ❍ Drink more water and limit sugary drinks
- ❍ Get the right amount of sleep
- ❍ I am not ready to work on a healthy habit

Only fill out if your child has asthma

Today's Date: _____

Patient's Name: _____

Childhood Asthma Control Test for children 4 to 11 years.

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to **the first four questions (1 to 4)**. If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining **three questions (5 to 7)** on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.

Step 4 Take the test to the doctor to talk about your child's total score.

19 or less If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions.

1. How is your asthma today?

0	1	2	3	SCORE
Very bad	Bad	Good	Very good	

2. How much of a problem is your asthma when you run, exercise or play sports?

0	1	2	3	
It's a big problem, I can't do what I want to do.	It's a problem and I don't like it.	It's a little problem but it's okay.	It's not a problem.	

3. Do you cough because of your asthma?

0	1	2	3	
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.	

4. Do you wake up during the night because of your asthma?

0	1	2	3	
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.	

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

TOTAL