TALLAHASSEE MEMORIAL HEALTHCARE

Pediatric Health Screenings

1425 Village Square Blvd, Suite 3
Tallahassee, Florida 32312
850-431-4445 (Phone)
850-431-6231 (Fax)

❖ Complete the following or mark NA (not applicable):

Chronic Problems:	**Hospitalizations / Surgeries & Dates (Month/Year)**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**

Diagnostics	**Consultations**
1.	**1.**
2.	**2.**
3.	**3.**

❖ Over the past 2 weeks, how often has your child been bothered by any of the following: *Please circle appropriate response*

	Not Applicable	**Not at all**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
Little interest/pleasure in doing things	NA	0	1	2	3
Feeling down, depressed or hopeless	NA	0	1	2	3

❖ **Nutrition:**
Recent Weight: ☐ No Change ☐ Gain _____lbs. ☐ Loss _____lbs.
Recent problems with eating/swallowing: ☐ YES ☐ NO

❖ **Physical/Emotional Abuse:**
Are you or your child in a relationship where you feel threatened or have been hurt? ☐ YES ☐ NO

❖ **Falls History & Risk Assessment:**
Do you feel your child is unsafe when he/she is up and walking around? ☐ YES ☐ NO ☐ NA
Has he/she had any falls within the last year? ☐ YES ☐ NO ☐ NA

❖ **TO BE COMPLETED BY THE THERAPIST DURING EVALUATION:**
☐ Falls Risk Education Sheet Given to Family? ☐ YES ☐ NO
☐ Physical Therapy Consult Recommended? ☐ YES ☐ NO
☐ Family declined a consult to physical therapy ☐ YES ☐ NO

☐ **Physicians**: Please be advised that due to the above answers the patient may require additional follow up.

Therapist Signature:_____ **Date:** _____ **Time:** _____

Physician Signature:_____ **Date:** _____ **Time:** _____

☐ **No physician signature required**

Sticker