

Comprehensive Screening (adult)

Patient Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

Which type of visit does your daughter need today?

Address a specific symptom or issue

- Medication questions/refills (list meds)
- Illness or Physical Symptoms
- Social, Emotional, Mood Concerns
- Sexuality, Gynecology
- Nutrition, Body Image
- Risk Behaviors, Safety
- Other: _____

OR

Annual Exam (well-check) which includes

- School / camp / college physical forms
- Annual disability paperwork
- Immunizations
- Wellness screening labs
- Brief update of chronic, stable conditions
- Refill of medications (no changes or problems)
- General health education

Please Explain

If the physician conducts **BOTH** types of services, additional fees may be charged or a separate appointment may be needed.

- **Additional FEES:** Please understand that most insurance companies do not pay for care of problems and preventive care on the same day. The patient would be responsible for the additional fees.
- **Additional TIME:** There may not be enough time to thoroughly address everything. Another appointment may be needed to fully address all the issues.

Your Name: _____ Relationship to Patient: Mother Father Other: _____

Signature: _____ Date: ___/___/___

Please give to the front desk staff:

- Immunization Records Forms (e.g. camp, sports) that require medical provider signature

If new patient, who referred you to Girls to Women?

Referred by: _____ physician therapist Other: _____



Overall, how is she is doing...	Doing Well / No concerns	Minor Concerns	Major/ Significant Concerns	Please describe
Physical Health Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
School/ Work general level of motivation, work ethic, attendance, performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Relationships outside the home friends, teachers, co-worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family Relationships parents, siblings and others at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Care basic hygiene, bathing, sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nutrition/ Body Image eating patterns, self-image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Health Puberty, sexual development, sexual identity, birth control, sexually transmitted diseases, pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood/ Attitude general level of happiness, optimism, work ethic, hopefulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risk Behavior inappropriate internet and/or cell phone use; alcohol / marijuana / drug use; sneaking out; inappropriate sexual behaviors/relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Safety Concerns self-harm, suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

About your daughter... Your relationship to Patient: Mother Father Other: _____

What about her makes you proud? _____

What seems to be the greatest challenge for her? _____

_____ **% (out of 100) Overall Functional Assessment:** Compared to what you think would be “normal, healthy life functioning”, how do YOU THINK you/your child is doing (no right or wrong answer, just your best guess)?



Current Medications

Medication Name	Dose	Prescribing Physician	Need Refill?	Quantity Needed
			<input type="checkbox"/> Yes	<input type="checkbox"/> 30 day <input type="checkbox"/> 90 day
			<input type="checkbox"/> Yes	<input type="checkbox"/> 30 day <input type="checkbox"/> 90 day
			<input type="checkbox"/> Yes	<input type="checkbox"/> 30 day <input type="checkbox"/> 90 day
			<input type="checkbox"/> Yes	<input type="checkbox"/> 30 day <input type="checkbox"/> 90 day

Medical History

Prenatal / Birth History: Normal Issues/Concerns: _____

Overall Growth and Development: Normal Issues/Concerns: _____

Age of first period: _____ or Have not started period

Medication Allergies (and reaction) _____

Food/Other Allergies (and reaction) _____

Any surgeries (physician, approximate age or date) _____

Any Hospitalizations (clinic/hospital/treatment center, approximate age or date) _____

Most recent Annual (Wellness) exam: Approximate Age or Date: _____ Physician: _____

Most recent lab tests

Cholesterol Approximate Age or Date: _____ Results: Normal Abnormal

Anemia Approximate Age or Date: _____ Results: Normal Abnormal

Other Approximate Age or Date: _____ Results: Normal Abnormal

Patient Social History

School: _____ Current Grade (e.g. 7th): _____ School Year (e.g 2015-2016) _____

Activities, Clubs, Hobbies: _____

Employment: _____

	Who does patient live with most of the time?	Occupation	Parents are:
Mother	<input type="checkbox"/>		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced (<input type="checkbox"/> Mom remarried <input type="checkbox"/> Dad remarried) <input type="checkbox"/> Widowed If patient lives in more than one home, what are the custodial arrangements?
Father	<input type="checkbox"/>		
Step-Mother	<input type="checkbox"/>		
Step-Father	<input type="checkbox"/>		
Brother(s)	<input type="checkbox"/>	Ages: _____	
Sister(s)	<input type="checkbox"/>	Ages: _____	



Patient Medical Issues (Past or Present) Check this box if none apply

	Age of Diagnosis	Specialist	Current Status (Please explain)
Allergy/Asthma/Immunology <input type="checkbox"/> asthma <input type="checkbox"/> seasonal allergies <input type="checkbox"/> food allergies <input type="checkbox"/> frequent infections <input type="checkbox"/> immune deficiency <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Dermatology <input type="checkbox"/> acne <input type="checkbox"/> eczema <input type="checkbox"/> birthmarks <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Gastroenterology <input type="checkbox"/> irritable bowel syndrome <input type="checkbox"/> reflux,GERD, heartburn <input type="checkbox"/> chronic constipation <input type="checkbox"/> Crohn's or ulcerative colitis <input type="checkbox"/> celiac disease <input type="checkbox"/> gall bladder / liver disease <input type="checkbox"/> blood in stools <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Endocrine <input type="checkbox"/> thyroid disorder <input type="checkbox"/> diabetes type 1 <input type="checkbox"/> diabetes type 2 <input type="checkbox"/> PCOS <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Orthopedic <input type="checkbox"/> broken bones <input type="checkbox"/> arthritis <input type="checkbox"/> scoliosis <input type="checkbox"/> joint problems <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Infectious Disease <input type="checkbox"/> chicken pox <input type="checkbox"/> mononucleosis <input type="checkbox"/> recurrent pneumonia <input type="checkbox"/> recurrent sinus infections <input type="checkbox"/> MRSA <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic

Patient Medical Issues (Past or Present) Check this box if none apply

	Age of Diagnosis	Specialist	Current Status (Please explain)
Cardiovascular/Hematology <input type="checkbox"/> anemia (explain type) <input type="checkbox"/> heart murmur <input type="checkbox"/> abnormal heart valve(s) <input type="checkbox"/> fainting or dizziness with exercise <input type="checkbox"/> bleeding disorder <input type="checkbox"/> blood clot / clotting disorder <input type="checkbox"/> high cholesterol <input type="checkbox"/> high blood pressure <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Neurology <input type="checkbox"/> migraines <input type="checkbox"/> tics <input type="checkbox"/> seizures <input type="checkbox"/> other			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Gynecology/Urology <input type="checkbox"/> recurrent urinary tract infections <input type="checkbox"/> kidney problems <input type="checkbox"/> severe menstrual cramps <input type="checkbox"/> irregular periods <input type="checkbox"/> ovarian cyst(s) <input type="checkbox"/> sexually transmitted infection <input type="checkbox"/> pregnancy <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Neurodevelopmental <input type="checkbox"/> birth complications <input type="checkbox"/> developmental delay <input type="checkbox"/> genetic disorder <input type="checkbox"/> learning disorder <input type="checkbox"/> autism <input type="checkbox"/> Asperger's <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> speech or language delay <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic
Psychological <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> eating disorder <input type="checkbox"/> alcohol use <input type="checkbox"/> drug use <input type="checkbox"/> tobacco use <input type="checkbox"/> suicide attempt <input type="checkbox"/> cutting / self-harm behavior <input type="checkbox"/> other:			<input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Problematic

Family MEDICAL History or Check this box if none apply

	Mother	Father	Siblings	Grandparents	Other
Asthma					
Bleeding or clotting disorders					
Blood disorders or sickle cell anemia					
Heart attack/stroke					
High blood pressure					
High cholesterol					
Kidney disease					
PCOS					
Migraine headaches					
Obesity					
Diabetes					
Thyroid disease					
Crohns/ulcerative colitis					
Rheumatoid arthritis					
Cancer (type) (_____)					
Other					

Family MENTAL HEALTH History or Check this box if none apply

	Mother	Father	Siblings	Grandparents	Other
Depression					
Anxiety					
OCD					
Bipolar					
Schizophrenia					
Learning disability					
ADD/ADHD					
Alcohol/drug abuse					
Eating disorder					
Suicide					
Other					