HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Name_____ **Birthdate**_____ **Gender**_____

Address_____ City_____ State/Zip_____

Parent/Guardian_____ Phone(H)_____(W)_____

PHYSICAL EXAMINATION – To be completed by health care provider approved to perform health assessments.

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance Integument Head – Neck EENT Oral – Dental Thorax Breasts Cardiovascular Abdomen Musculoskeletal Genitourinary Neurological		Height: Weight: Allergies:

Significant Assessment Findings:

Recommendations: (Include referrals, attach additional information)

_____ _____ **Phone Number**: _____

Date **Signature of MD, DO, PA, APRN**

_____ **Address:** _____

Print Name of MD, DO, PA, APRN

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