PHALCON LABEL
Name ______________________________
Date of Service ______________________________
CHR # ______________________________

CHILD HEALTH ASSESMENT RECORD

VISIT TYPE: ______________________________

Who brought child in today? ______________________ Was child premature? ❑ Yes ❑ No #wks________

Does the parent/caretaker have specific concerns about this child today? ______________________

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Allergies:____

Medications (prescription and nonprescription): ______________________________

Anticipatory Guidance done per protocol: ❑ Yes ❑ No Comments:______________________

Developmental Assessment: ❑ Pass ❑ Fail ❑ Categories if failed: ______________________

Mark developmental assessment tool used: ❑ Developmental Assessment Chart ❑ ASQ-3

Lead risk status: ❑ Low ❑ High Reason if high:______________________________

Date of last lead test if not done at health department: ______________________________

Under Dental Care: ❑ Yes ❑ No ❑ Referred

Care Coordination referral indicated: ❑ No ❑ Yes Reason if yes:______________________

Nutrition Assessment: ❑ Normal ❑ Abnormal ❑ Comments if abnormal: __________________

Vision: Objective acuity: Left ____ Right ____ Subjective acuity : ❑ Grossly Normal ❑ Grossly Abnormal

Hearing: Objective: 25dB @ 500Hz Left ❑ Yes ❑ No Right ❑ Yes ❑ No

25dB @ 4,000Hz Left ❑ Yes ❑ No Right ❑ Yes ❑ No

Subjective: ❑ Grossly Normal ❑ Grossly Abnormal

Sexually active: ❑ Yes ❑ No LMP______ Birth control ❑ Yes ❑ No ❑ Family Planning referral

Signature/Title: ____

SYSTEMS REVIEW

A.	General Appearance:	❑ Normal ❑ Abnormal
B.	Integument	❑ Normal ❑ Abnormal
C.	HEENT:	❑ Normocephalic ❑ TMS intact ❑ PERRLA ❑ Nose clear ❑ Throat clear
D.	Lungs:	❑ Clear bilaterally ❑ Abnormal breath sounds
E.	Cardiovascular:	❑ No murmur ❑ Normal rate/rhythm
F.	Abdominal:	❑ Soft ❑ Non-tender ❑ Bowel sounds present
G.	Genitourinary/ Reproductive:	❑ No breast lesions/discharge ❑ BSE taught ❑ Normal female genitalia ❑ Testes descended ❑ Normal male genitalia ❑ Testicular Self exam Tanner Stage _____
H.	Musculoskeletal:	❑ No edema ❑ ROM normal ❑ Negative scoliosis screen
I.	Neurological:	❑ Gait normal ❑ Reflexes intact

Describe assessment findings including referrals and future plans:

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Signature/Title:______________________________________ Date: ________________

Translator name/# if applicable:____

CHR 12