

Belilovsky Pediatrics  
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 Brooklyn, NY 11235  
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**6  
YRS**

ID Sticker:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**WELL CHILD ASSESSMENT  
(6 YEARS)**

Informant: \_\_\_\_\_ Allergies: \_\_\_\_\_

Current Medications (See summary list): \_\_\_\_\_

Measurements: Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ B.P. \_\_\_\_\_ / \_\_\_\_\_ Temp. \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_

Are you feeling pain now?  Yes  No

**BMI / Percentile :**

**Pain Scale**

	<b>NO PAIN</b>		<b>MODERATE PAIN</b>		<b>WORST PAIN</b>	
0		2		4		6
						8
						10

MA Signature: \_\_\_\_\_

Risk Assessment:	Yes	No	IF Patient at Risk then Counseled for:	Chief Concern
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TB	_____
Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lead	_____
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cholesterol	_____
Tobacco/Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tobacco/Smoking	_____
Drugs/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Drugs/Alcohol	_____
Violence (includes schoolyard and firearms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Violence (includes schoolyard and firearms)	_____

Interval History: Personal \_\_\_\_\_

Family \_\_\_\_\_

Physical Exam:	normal	abnormal*	normal	abnormal*	Explain Abnormals
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	
Head/ Neck	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	
Eyes/Vision	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	
Ear/Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	
Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	Pulses	<input type="checkbox"/>	
Nodes:	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	
Teeth/Gums	<input type="checkbox"/>	<input type="checkbox"/>	Neuro	<input type="checkbox"/>	
			Genitalia	<input type="checkbox"/>	
			Anus	<input type="checkbox"/>	

\*indicate on progress note

**Development:**

- |   |                       |
|---|-----------------------|
| _____ Ride bicycle                          | _____ Ties shoelaces  |
| _____ Draws people with 6 parts and clothes | _____ Copies triangle |
| _____ Share a book                          |                       |
- Social Assessment Done: \_\_\_\_\_ Social work referral  yes  No

**Nutritional:**

- \_\_\_\_\_ Balanced diet, no junk food \_\_\_\_\_ Maintain appropriate weight
- \_\_\_\_\_ Use of herbs/vitamins

**Parenting:**

- |  |   |
|--|---|
| _____ Establish bedtime hour                   | _____ Bicycle helmet and safety   |
| _____ Monitor TV viewing / programs            | _____ Seat belt usage   |
| _____ Promote out of home activities           | _____ Good touch / bad touch  |
| _____ Encourage reading, hobby - library card  | _____ Firearms  |
| _____ Allowance                                | _____ Learns to swim with supervision                                     |
| _____ Praise, encourage, affection each child  | _____ Stranger awareness  |
| _____ Show interest in child activity / school | _____ Seasonal safety issues (eg. travel advice, environmental exposures) |
| _____ "Time out" / rewards / sanctions         | _____ Risk Reduction: Drugs, Alcohol, Tobacco                             |

**Good Health Habits:**

- \_\_\_\_\_ Dental care ( brushing, flossing, dental visits)
- \_\_\_\_\_ Peer Relationships
- \_\_\_\_\_ Evaluate communications/ relationships (friends/family)

Immunization:  Complete  Incomplete  Flu RA

RA = Risk Assessment O = objective S = Subjective

Impressions:

Plans: \_\_\_\_\_ Vision (O) \_\_\_\_\_ Hearing (O)

Provider Signature: \_\_\_\_\_

Provider Stamp/Print: \_\_\_\_\_

**Nutritional Behavior**

Nutritional Education Material given (including kidshealth.org web site).

Patient Nutritional Assessment Done (includes BMI / Percentile)

Nutritional Referral Indicated.  
 Yes  NO

**Physical Activity / Fitness**

Educational Materials Given (Includes kidshealth.org website)

Present Activity/Exercise Reviewed and Advise Given.