NEWBORN-1 MONTH WCC

Child's Name_____ Date _____ DOB_____

Wt _____ (th%), Ht _____ (th%), HC_____ (th%), T_____, HR _____, RR _____

Reason for Visit / Concerns_____

Prenatal-Birth-Neonatal History

Maternal Gravida____, Para____, Prenatal care Y N

Maternal Health_____

Length of preg _____, Delivery route _____

Apgars _____, Days in hosp _____, Wt at disch _____

Interval History_____

Diet

Breast Y N Formula_____ Freq._____

Amt/ 24 hr._____ Other Foods Y N _____

Concerns _____

Elimination

BM Freq/Day_____ Appearance_____

Voiding Frequency _____ NL stream Y N

Concerns_____

Sleep

urs/noc_____ Naps/day _____ length_____

Sleep location _____ Position_____

Concerns_____

Growth and Development

Follows to midline Y N, Regards face Y N, Lifts head Y N, Equal movement of extr. Y N, Responds to sound Y N, Vocalizes Y N, Sucks well Y N

Concerns_____

Behavior/Personality

Describe Child _____

Crying periods Y N, How managed _____

Discipline: reasons for _____

Method used _____

Parent-Child Interaction

Infant held close Y N Comforted Y N Monitored Y N

Other observations_____

Day Care

Return to work plans_____

Current child care arrangements_____

Concerns_____

Current Safety Practices

Car seat Y N Smoke alarm Y N Fall prevention Y N

Childproof home Y N Sibling supervision Y N

Guns in home Y N Hot Water Safety Y N, CPR Y N

Family Social / Health History

Family Members_____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who?_____

EtOH/drugs Y N Who?_____Illness Y N_____

Concerns _____

Review of Systems (circle positive findings)	Physical Exam (check ☐ if WNL)	
fever, illness, hospitalization, injury	General	☐
bulging fontanelle, rash, seborrhea, asymmetry	Head	☐
discharge, redness, strabismus, tearing	Eyes	☐
rubbing, irritability, suspicion of infection, discharge	Ears	☐
S/S URI, allergy, rhinorrhea	Nose	☐
abcess, swelling of gums/teeth, oral lesion, drooling	Mouth	☐
rash, dry skin, moles, birth marks	Skin	☐
palpable nodes, limited ROM, difficulty swallowing	Neck/Throat	☐
cough, wheeze, retractions, flaring, grunting	Chest	☐
pallor, cyanosis, difficulty feeding, diaphoresis	Cardio	☐
od allergy, diarrhea, constipation, emesis, swelling	Abdomen	☐
erythema, rash, poor stream, pus or hematuria	Genitalia	☐
limited ROM, hip/feet deformity, Fx	Mus/Skel	☐
tremors, lethargy, irritability, seizures, LOC	Neuro	☐

NEWBORN-1 MONTH WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA _____ ☐ PPD _____ ☐ Tine _____
☐ DDST _____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Falls ☐ Water/Water heater temp. ☐ Fire ☐ Head support ☐ Firearms
☐ Walkers ☐ Carseat ☐ Choking ☐ Sleeping position ☐ Sibling safety
Other _____

G & D ☐ Increased head control ☐ Roll over/ scoot ☐ Response to sound ☐ Vocalizes
☐ Spontaneous smile ☐ Sleep counseling ☐ Crying counseling ☐ Stimulation needs
☐ Signs and symptoms of illness/when to contact practitioner ☐ Temperature taking
Other _____

Nutrition ☐ Importance of Mothers diet (if BF) ☐ Appropriate amounts formula / BF
☐ No other foods ☐ Night feeding ☐ Tx hiccoughs ☐ Tx for Constipation/Diarrhea
☐ Vitamin/Flouride supplementation ☐ Sucking needs ☐ No propping
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Content by Pat Jackson, Design by Steve Elias

Provider Signature _____

PEDIATRIC 2-3 MONTH WCC

Child's Name _____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), HC _____ (th%), T _____, HR _____, RR _____

Reason for Visit / Concerns _____

Interval History

_____

_____

_____

Injuries? _____

Diet

Breast Y N Formula _____ Freq. _____

Amt/ 24 hr. _____ Other Foods Y N _____

Concerns _____

Elimination

BM Freq/Day _____ Appearance _____

Voiding Frequency _____ NL stream Y N

Concerns _____

Sleep

Hours/noc _____ Naps/day _____ length _____

Sleep location _____ Position _____

Concerns _____

Growth and Development

Head up 45deg. Y N, Equal movements extr. Y N

Regards face Y N, Spont. smile Y N, Follows to midline Y N,

Responds to sound Y N, Vocalizes Y N

Concerns _____

Behavior/Personality

Describe Child _____

Crying periods Y N, How Managed _____

Discipline: reasons for _____

Method used _____

Parent-Child Interaction

Infant held close Y N Comforted Y N Monitored Y N

Other observations _____

Day Care

Attending? Y N where _____

Frequency _____

Concerns _____

Current Safety Practices

Car seat Y N Smoke alarm Y N Fall prevention Y N

Childproof home Y N Ipecac/poison control Y N

Guns in home Y N Hot Water Safety Y N, CPR Y N

Family Social / Health History

Family Members _____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who? _____

EtOH/drugs Y N Who? _____ Illness Y N _____

Concerns _____

Review of Systems (circle positive findings)	Physical Exam	(check ☐ if WNL)
fever, illness, hospitalization, injury	General	☐
bulging fontanelle, rash, seborrhea, asymmetry	Head	☐
discharge, redness, strabismus, tearing	Eyes	☐
rubbing, irritability, suspicion of infection, discharge	Ears	☐
S/S URI, allergy, rhinorrhea	Nose	☐
abcess, swelling of gums/teeth, oral lesion, drooling	Mouth	☐
rash, dry skin, moles, birth marks	Skin	☐
palpable nodes, limited ROM, difficulty swallowing	Neck/Throat	☐
cough, wheeze, retractions, flaring, grunting	Chest	☐
pallor, cyanosis, difficulty feeding, diaphoresis	Cardio	☐
d allergy, diarrhea, constipation, emesis, swelling	Abdomen	☐
ythema, rash, poor stream, pus or hematuria	Genitalia	☐
limited ROM, hip/feet deformity, Fx	Mus/Skel	☐
tremors, lethargy, irritability, seizures, LOC	Neuro	☐

PEDIATRIC 2-3 MONTH WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA_____ ☐ PPD_____ ☐ Tine_____
☐ DDST_____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Water/Water heater temp. ☐ Fire ☐ Poison/Ipecac ☐ Firearms ☐ Falls
☐ Walkers ☐ Carseat ☐ Choking ☐ Child proofing of home ☐ Sibling safety
Other _____

G & D ☐ Increased head control ☐ Roll over / scoot ☐ Turn to voice
☐ Recognizes familiar caretaker ☐ Laughs / squeals ☐ Reach / grasp coordination
☐ Responsive smile ☐ Sleep counseling ☐ Crying counseling ☐ Stimulation needs
Other _____

Nutrition ☐ Importance of Mothers diet (if BF) ☐ Formula prep / appropriate amounts
☐ Intro of new foods ☐ Night feeding ☐ Sucking needs ☐ No propping
☐ Vitamin/Flouride supplementation ☐ Tx for constipation / diarrhea
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Content by Pat Jackson, Design by Steve Ellas

Provider Signature _____

PEDIATRIC 4-6 MONTH WCC

Child's Name _____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), HC _____ (th%), T _____, HR _____, RR _____

Reason for Visit / Concerns _____

Interval History

_____

_____

_____

Injuries? _____

Diet

Breast Y N Formula _____ Freq. _____

Amt/ 24 hr. _____ Other Foods Y N _____

Concerns _____

Elimination

BM Freq/Day _____ Appearance _____

Voiding Frequency _____ NL stream Y N

Concerns _____

Sleep

Hours/noc _____ Naps/day _____ length _____

location _____ Position _____

Concerns _____

Growth and Development

Head steady Y N, head up 90 degrees Y N, rolls over Y N

reaches/grasp Y N, hand/mouth coor. Y N,

turns to voice Y N, Imitates sound Y N, regards raisin Y N

Concerns _____

Behavior/Personality

Describe Child _____

Crying periods Y N, How Managed _____

Discipline: reasons for _____

Method used _____

Parent-Child Interaction

Infant held close Y N Comforted Y N Monitored Y N

Other observations _____

Day Care

Attending? Y N where _____

Frequency _____

Concerns _____

Current Safety Practices

Car seat Y N Smoke alarm Y N Fall prevention Y. N

Childproof home Y N Ipecac/poison control Y N

Guns in home Y N Hot Water Safety Y N, CPR Y N

Family Social / Health History

Family Members _____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who? _____

EtOH/drugs Y N Who? _____ Illness Y N _____

Concerns _____

Review of Systems (circle positive findings)	Physical Exam (check ☐ if WNL)
fever, illness, hospitalization, injury	General ☐
bulging fontanelle, rash, seborrhea, asymmetry	Head ☐
discharge, redness, strabismus, tearing	Eyes ☐
rubbing, irritability, suspicion of infection, discharge	Ears ☐
S/S URI, allergy, rhinorrhea	Nose ☐
abcess, swelling of gums/teeth, oral lesion, drooling	Mouth ☐
rash, dry skin, moles, birth marks	Skin ☐
palpable nodes, limited ROM, difficulty swallowing	Neck/Throat ☐
cough, wheeze, retractions, flaring, grunting	Chest ☐
pallor, cyanosis, difficulty feeding, diaphoresis	Cardio ☐
allergy, diarrhea, constipation, emesis, swelling	Abdomen ☐
erythema, rash, poor stream, pus or hematuria	Genitalia ☐
limited ROM, hip/feet deformity, Fx	Mus/Skel ☐
tremors, lethargy, irritability, seizures, LOC	Neuro ☐

PEDIATRIC 4-6 MONTH WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA_____ ☐ PPD_____ ☐ Tine_____
☐ DDST_____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Water/Water heater temp. ☐ Fire ☐ Poison/Ipecac ☐ Firearms ☐ Falls
☐ Walkers ☐ Carseat ☐ Choking ☐ Child proofing of home ☐ Sibling safety
Other _____

G & D ☐ Increased trunk control ☐ Roll over/ scoot / crawl ☐ Turn to voice
☐ Recognizes familiar caretaker ☐ Imitates sounds ☐ Hand/mouth coordination
☐ Responsive smile ☐ Sleep counseling ☐ Crying counseling ☐ Stimulation needs
Other _____

Nutrition ☐ Importance of Mothers diet (if BF) ☐ Appropriate amounts formula/solids
☐ Intro of new foods ☐ Night feeding ☐ Sources of Iron ☐ Tx for Constipation/Diarrhea
☐ Vitamin/Flouride supplementation ☐ Introduction of finger foods / table foods
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Content by Pat Jackson, Design by Steve Elias

Provider Signature_____

PEDIATRIC 7-12 MONTH WCC

Child's Name _____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), HC _____ (th%), T _____, HR _____, RR _____

Reason for Visit / Concerns _____

Interval History

_____

_____

_____

Injuries? _____

Diet

Breast Y N Formula _____ Amt / 24 hr _____

Other Foods (type/amt) _____

Concerns _____

Elimination

BM Freq/Day _____ Appearance _____

Voiding Frequency _____ NL stream Y N

Concerns _____

Sleep

Hours/noc _____ Naps/day _____ length _____

ep location _____ Habits _____

Concerns _____

Growth and Development

Sitting Y N, Crawling Y N, Stand holding Y N, Walking Y N,

Mama/Dada Y N, Jabbers Y N, Imitates sounds Y N,

Pincer grasp Y N, Feeds self Y N, Pat-a-cake Y N

Concerns _____

Behavior/Personality

Describe Child _____

Crying periods Y N, How Managed _____

Discipline: reasons for _____

Method used _____

Parent-Child Interaction

Child held close Y N Comforted Y N Monitored Y N

Other observations _____

Day Care

Attending? Y N where _____

Frequency _____

Concerns _____

Current Safety Practices

Car seat Y N, Smoke alarm Y N, Fall prevention Y N

Childproof home Y N, Ipecac/poison control Y N, CPR Y N

Guns in home Y N, Hot Water Safety Y N, Eating safety Y N

Family Social / Health History

Family Members _____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who? _____

EtOH/drugs Y N Who? _____ Illness Y N _____

Concerns _____

Review of Systems (circle positive findings)	Physical Exam (check ☐ if WNL)
fever, illness, hospitalization, injury	General ☐
bulging fontanelle, rash, seborrhea, asymmetry	Head ☐
discharge, redness, strabismus, tearing	Eyes ☐
rubbing, irritability, suspicion of infection, discharge	Ears ☐
S/S URI, allergy, rhinorrhea	Nose ☐
abcess, swelling of gums/teeth, oral lesion, drooling	Mouth ☐
rash, dry skin, moles, birth marks	Skin ☐
palpable nodes, limited ROM, difficulty swallowing	Neck/Throat ☐
cough, wheeze, retractions, flaring, grunting	Chest ☐
pallor, cyanosis, difficulty feeding, diaphoresis	Cardio ☐
l allergy, diarrhea, constipation, emesis, swelling	Abdomen ☐
erythema, rash, poor stream, pus or hematuria	Genitalia ☐
limited ROM, hip/feet deformity, Fx	Mus/Skel ☐
tremors, lethargy, irritability, seizures, LOC	Neuro ☐

PEDIATRIC 7-12 MONTH WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA _____ ☐ PPD _____ ☐ Tine _____
☐ DDST _____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Water/Water heater temp. ☐ Fire ☐ Poison/Ipecac ☐ Firearms ☐ Falls
☐ Walkers ☐ Carseat ☐ Eating safety ☐ Child proofing of home ☐ Sibling safety
Other _____

G & D ☐ Sitting ☐ Pull to stand / walk ☐ Increased mobility ☐ Hand/mouth coordination
☐ Stranger anxiety ☐ Imitates sounds ☐ Use of words ☐ Pincer grasp
☐ Scribble ☐ Sleep counseling ☐ Crying counseling ☐ Discipline counseling
Other _____

Nutrition ☐ Use of formula until 1 yr ☐ Appropriate amounts formula/solids ☐ Use of cup
☐ Intro of new foods ☐ Night bottle ☐ Sources of Iron ☐ Finger foods / table foods
☐ Vitamin/Flouride supplementation ☐ Tx constipation / diarrhea ☐ Decreased appetite
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Content by Pat Jackson, Design by Steve Ellas.

Provider Signature _____

PEDIATRIC 13-23 MONTH WCC

Child's Name _____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), HC _____ (th%), T _____, HR _____, RR _____

Reason for Visit / Concerns _____

Interval History

_____

_____

_____

Injuries? _____

Diet

Type of milk _____, Amt/24/hr _____, Bottle Y N

Veg _____ Bread/Cereal _____

Fruit _____ Meats/Beans _____ Sweets _____

Concerns _____

Elimination

BM Freq/Day _____ Appearance _____

Voiding Frequency _____ Toilet trng Started Y N

Concerns _____

Sleep

Hours/noc _____ Naps/day _____ length _____

location _____ Habits _____

Concerns _____

Growth and Development

Walks well Y N, Runs Y N, Climbs stairs Y N, Toss ball Y N,

Scribbles Y N, Removes clothes Y N, Uses spoon Y N,

Brushes Teeth Y N, # of understandable words _____

Concerns _____

Behavior/Personality/Interaction

Describe Child _____

Temper tantrums Y N, How Managed _____

Discipline: reasons for _____

Method used _____

Adaptable Y N, Plays well with others Y N, Shares Y N

Aggressive Y N, How managed _____

Amt of TV/24hrs _____, Read to daily Y N

Concerns _____

Day Care

Attending? Y N where _____

Frequency _____

Concerns _____

Current Safety Practices

Car seat Y N, Smoke alarm Y N, Fall prevention Y N

Childproof home Y N, Ipecac/poison control Y N, CPR Y N

Guns in home Y N, Hot Water Safety Y N, Street safety Y N

Family Social / Health History

Family Members _____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who? _____

EtOH/drugs Y N Who? _____ Illness Y N _____

Concerns _____

Review of Systems (circle positive findings)		Physical Exam (check ☐ if WNL)
fever, illness, hospitalization, injury	General	☐
swelling, rash, seborrhea, asymmetry, loss of hair	Head	☐
discharge, redness, strabismus, tearing	Eyes	☐
rubbing, irritability, suspicion of infection, discharge	Ears	☐
S/S URI, allergy, rhinorrhea, bleeding	Nose	☐
caries, abcess, swelling of gums/teeth, oral lesion	Mouth	☐
rash, dry skin, moles, birth marks, warts, lesions	Skin	☐
palpable nodes, limited ROM, sore throat	Neck/Throat	☐
cough, wheeze, retractions, flaring, Tb history	Chest	☐
pallor, cyanosis, exercise intolerance, diaphoresis	Cardio	☐
allergy, diarrhea, constipation, emesis, swelling	Abdomen	☐
erythema, rash, pus or hematuria, dysuria, freq.	Genitalia	☐
limited ROM, change in gait/strength, Fx	Mus/Skel	☐
tremors, lethargy, irritability, seizures,headache LOC	Neuro	☐

PEDIATRIC 13-23 MONTH WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA_____ ☐ PPD_____ ☐ Tine_____
☐ DDST_____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Water/Water heater temp. ☐ Fire ☐ Poison/Ipecac ☐ Firearms ☐ Falls
☐ Carseat ☐ Eating safety ☐ Child proofing of home ☐ Street safety
Other _____

G & D ☐ Speech development ☐ Temper tantrums ☐ Toilet training ☐ Autonomy
☐ Reading versus TV ☐ Imitates behavior ☐ Limit setting ☐ Time out
☐ Scribble ☐ Sleep counseling ☐ Crying counseling ☐ Discipline counseling
Other _____

Nutrition ☐ Appropriate amounts of milk ☐ Balanced diet ☐ Food dislikes ☐ Iron sources
☐ Decreased appetite ☐ Limited sweets ☐ No night bottle ☐ Dental care
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Content by Pat Jackson, Design by Steve Elias

Provider Signature_____

PEDIATRIC 2-3 YEAR WCC

Child's Name _____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), T _____, HR _____, RR _____

Reason for Visit / Concerns _____

Interval History

_____

_____

_____

Injuries? _____

Diet

Type of milk _____, Amt/24/hr _____, Bottle Y N

Veg _____ Bread/Cereal _____

Fruit _____ Meats/Beans _____ Sweets _____

Concerns _____

Elimination

BM Freq/Day _____ Voiding Frequency _____

Toilet trained Day Y N, Toilet trained Night Y N

Concerns _____

Sleep

Hours/noc _____ Naps/day _____ length _____

location _____ Habits _____

Concerns _____

Growth and Development

Jump Y N, Kick ball Y N, Throw ball Y N, Wash hands Y N,

Removes clothes Y N, Body parts >6 Y N, Combine words Y N,

Names friend Y N, 1/2 Speech understood Y N,

Concerns _____

Behavior/Personality/Interaction

Describe Child _____

Temper tantrums Y N, How Managed _____

Discipline: reasons for _____

Method used _____

Adaptable Y N, Plays well with others Y N, Shares Y N

Aggressive Y N, How managed _____

Amt of TV/24hrs _____, Read to daily Y N

Concerns _____

Day Care

Attending? Y N where _____

Frequency _____

Concerns _____

Current Safety Practices

Car seat Y N, Smoke alarm Y N, Fall prevention Y N

Childproof home Y N, Ipecac/poison control Y N, CPR Y N

Guns in home Y N, Hot Water Safety Y N, Street safety Y N

Family Social / Health History

Family Members _____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who? _____

EtOH/drugs Y N Who? _____ Illness Y N _____

Concerns _____

Review of Systems (circle positive findings)

fever, illness, hospitalization, injury	General
swelling, rash, seborrhea, asymmetry, loss of hair	Head
discharge, redness, strabismus, tearing	Eyes
rubbing, irritability, suspicion of infection, discharge	Ears
S/S URI, allergy, rhinorrhea, bleeding	Nose
caries, abcess, swelling of gums/teeth, oral lesion	Mouth
rash, dry skin, moles, birth marks, warts, lesions	Skin
palpable nodes, limited ROM, sore throat	Neck/Throat
cough, wheeze, retractions, flaring, Tb history	Chest
murmur, cyanosis, exercise intolerance	Cardio
allergy, diarrhea, constipation, emesis, swelling	Abdomen
erythema, rash, pus or hematuria, dysuria, freq.	Genitalia
limited ROM, change in gait/strength, Fx	Mus/Skel
tremors, lethargy, irritability, seizures, headache LOC	Neuro

Physical Exam (check ☐ if WNL)

General	☐
Head	☐
Eyes	☐
Ears	☐
Nose	☐
Mouth	☐
Skin	☐
Neck/Throat	☐
Chest	☐
Cardio	☐
Abdomen	☐
Genitalia	☐
Mus/Skel	☐
Neuro	☐

PEDIATRIC 2-3 YEAR WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA_____ ☐ PPD_____ ☐ Tine_____
☐ DDST_____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Water/Water heater temp. ☐ Fire ☐ Poison/Ipecac ☐ Firearms ☐ Falls
☐ Carseat ☐ Eating safety ☐ Child proofing of home ☐ Street safety
Other _____

G & D ☐ Speech development ☐ Temper tantrums ☐ Toilet training ☐ Autonomy
☐ Reading versus TV ☐ Imitates behavior ☐ Limit setting ☐ Time out
☐ Fine motor skills ☐ Sleep counseling ☐ Discipline counseling
Other _____

Nutrition ☐ Appropriate amounts of milk ☐ Balanced diet ☐ Food dislikes ☐ Iron sources
☐ Decreased appetite ☐ Limited sweets ☐ No night bottle ☐ Dental care
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Provider Signature _____

Content by Pat Jackson, Design by Steve Elias

PEDIATRIC 4-6 YEAR WCC

Child's Name_____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), BP_____,T_____, HR _____, RR _____

Reason for Visit / Concerns_____

Interval History

_____

_____

_____

Injuries?_____

Diet

Type of milk_____, Food allergies N Y_____

Veg_____Bread/Cereal_____

Fruit_____Meats/Beans_____Sweets_____

Concerns_____

Elimination

BM Freq/Day_____Toilet trained Day Y N,

Night Y N, Enuresis mgmt._____

Concerns_____

Sleep

Hrs/noc_____, Nightmares Y N, #/Week_____

Sleep location _____, Routine _____

Concerns_____

Growth and Development

Rides tri/bicycle Y N, Balance one foot Y N, Knows colors Y N,

Counts 5-10 Y N, All speech understood Y N, Writes name Y N

Knows name, address, phone # Y N, Plays with peers Y N

Concerns_____

Behavior/Personality/Interaction

Describe Child _____

Discipline: reasons for _____

Method used _____

Adaptable Y N, Plays well with others Y N, Shares Y N

Imaginative play Y N, Dresses self Y N

Aggressive Y N, How managed_____

Amt of TV / video / 24hrs_____, Read to daily Y N

Concerns_____

Day Care/Pre School/School

Attending? Y N where _____, Freq._____

Enjoys? Y N, Doing well Y N, Expected attention span Y N

Concerns_____

Current Safety Practices

Seat belt Y N, Water safety Y N, Bike safety Y N, CPR Y N,

Helmet use Y N, Street safety Y N, Firearms Y N,

Poison control Y N, Stranger awareness Y N, Matches Y N

Family Social / Health History

Family Members_____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who?_____

EtOH/drugs Y N Who?_____Illness Y N_____

Concerns _____

Review of Systems (circle positive findings)	Physical Exam (check ☐ if WNL)	
fever, illness, hospitalization, injury	General	☐
swelling, rash, seborrhea, asymmetry, loss of hair	Head	☐
discharge, redness, strabismus, tearing	Eyes	☐
rubbing, irritability, suspicion of infection, discharge	Ears	☐
S/S URI, allergy, rhinorrhea, bleeding	Nose	☐
caries, abcess, swelling of gums/teeth, oral lesion	Mouth	☐
rash, dry skin, moles, birth marks, warts, lesions	Skin	☐
inc. nodes, limited ROM, sore throat, Hx strep	Neck/Throat	☐
cough, wheeze, retractions, flaring, Tb history	Chest	☐
murmur, cyanosis, exercise intolerance	Cardio	☐
food allergy, diarrhea, constipation, emesis, pain	Abdomen	☐
erythema, rash, pus or hematuria, dysuria, freq.	Genitalia	☐
limited ROM, change in gait/strength, Fx	Mus/Skel	☐
tremors, lethargy, irritability, seizures,headache LOC	Neuro	☐

PEDIATRIC 4-6 YEAR WCC

Assessment/Dx	Problem List
	1. Health Care Maintenance
	2.
	3.
	4.

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA _____ ☐ PPD _____ ☐ Tine _____
☐ DDST _____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Cont. supervision needs ☐ Water/swimming ☐ Fire/matches ☐ Stranger safety
☐ Firearms ☐ Seat belt ☐ Helmet use ☐ Street safety ☐ 911 ☐ Phone #/address
Other _____

G & D ☐ Balance independence/need for limits ☐ Need for peer interaction ☐ Need for reg. P.E.
☐ Reading versus TV ☐ Limit TV / video ☐ Normal imaginative play ☐ Sexual identity
☐ Fine motor skills ☐ Assess school readiness ☐ Discipline counseling
Other _____

Nutrition ☐ Encourage variety of foods ☐ Small servings ☐ Food likes / dislikes ☐ Iron sources
☐ Pleasant meals ☐ Limit sweets ☐ Nutritious snacks ☐ Regular dental care
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

Provider Signature _____

Content by Pat Jackson, Design by Steve Ellis

PEDIATRIC 7-9 YEAR WCC

Child's Name_____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), BP_____,T_____, HR _____, RR _____

Reason for Visit / Concerns_____

Interval History

_____

_____

_____

Injuries?_____

Diet

Type of milk_____, Food allergies N Y_____

Reg break. Y N, Sweets/day Y N, Fast foods/week_____

Fruit/veg/day Y N, Meat/bean/day Y N, Bread/cereal/day Y N

Concerns_____

Elimination

BM Freq/Day_____, Wetting/soiling Day Y N,

Night Y N, Enuresis mgmt._____

Concerns_____

Sleep

Hours/noc_____, Nightmares Y N, #/Week_____

Bed location _____, Routine _____

Concerns_____

Growth and Development

Rides bicycle Y N, Plays sports Y N, Knows right/left Y N,

Reads Y N, Add/subtract Y N, Writes clearly Y N,

Knows name, address, phone # Y N, Tells jokes Y N

Concerns_____

Behavior/Personality/Interaction

Describe Self _____

Discipline: reasons for _____

Method used _____

Independent Y N, Confident Y N, Enjoys peers Y N

Reality vs. fantasy Y N, Sense of humor Y N, Chores Y N,

Aggressive Y N, How managed_____

Amt of TV / video / 24hrs_____, Reads daily Y N

Concerns_____

School

Grade___, Where _____, Days missed/mo.____

Enjoys? Y N, Doing well Y N, Typical grades_____

Favorite subj_____,Least fav_____,Supv. aft. sch, Y N

Concerns_____

Current Safety Practices

Seat belt Y N, Water safety Y N, Bike safety Y N, CPR Y N,

Helmet use Y N, Street safety Y N, Firearms Y N,

Supervised? Y N, Stranger awareness Y N, Cooking Y N

Family Social / Health History

Family Members_____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who?_____

EtOH/drugs Y N Who?_____Illness Y N_____

Concerns _____

Review of Systems (circle positive findings)

fever, illness, hospitalization, injury	General
swelling, rash, seborrhea, asymmetry, loss of hair	Head
discharge, redness, strabismus, tearing	Eyes
rubbing, irritability, suspicion of infection, discharge	Ears
S/S URI, allergy, rhinorrhea, bleeding	Nose
caries, abcess, swelling of gums/teeth, oral lesion	Mouth
rash, dry skin, moles, birth marks, warts, lesions	Skin
inc. nodes, limited ROM, sore throat, Hx strep	Neck/Throat
cough, wheeze, retractions, flaring, Tb history	Chest
Hx murmur, cyanosis, exercise intolerance	Cardio
allergy, diarrhea, constipation, emesis, pain	Abdomen
erythema, rash, pus or hematuria, dysuria, freq.	Genitalia
limited ROM, change in gait/strength, Fx	Mus/Skel
tremors, lethargy, irritability, seizures,headache LOC	Neuro

Physical Exam (check ☐ if WNL)

General		☐
Head		☐
Eyes		☐
Ears		☐
Nose		☐
Mouth		☐
Skin		☐
Neck/Throat		☐
Chest	Tanner #	☐
Cardio		☐
Abdomen		☐
Genitalia	Tanner #	☐
Mus/Skel		☐
Neuro		☐

PEDIATRIC 7-9 YEAR WCC

Assessment/Dx

_____

_____

_____

_____

Problem List

1. Health Care Maintenance
2. _____
3. _____
4. _____

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA _____ ☐ PPD _____ ☐ Tine _____
☐ DDST _____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ Cont. supervision needs ☐ Water/swimming ☐ Fire/cooking ☐ Stranger safety
☐ Firearms ☐ Seat belt ☐ Helmet use ☐ Street safety ☐ 911 ☐ Phone #/address
Other _____

G & D ☐ Balance independence/need for limits ☐ Need for peer interaction ☐ Need for reg. P.E.
☐ Reading versus TV ☐ Limit TV / video ☐ Importance of schoolwork ☐ Family chores
☐ Encourage team activities ☐ Encourage responsibility ☐ Need for praise
Other _____

Nutrition ☐ Encourage variety of foods ☐ Varied appetites ☐ Need for breakfast ☐ Exercise vs. diet
☐ Limit fast foods ☐ Limit sweets ☐ Nutritious snacks ☐ Regular dental care
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

_____

_____

Content by Pat Jackson, Design by Steve Ellas

Provider Signature _____

PEDIATRIC 10-13 YEAR WCC

Child's Name_____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), BP_____,T_____, HR _____, RR _____

Reason for Visit / Concerns_____

Interval History

_____

_____

_____

Injuries?_____

Diet

Satisfied with weight Y N, Food allergies N Y_____

Reg break. Y N, Sweets/day Y N, Fast foods/week_____

Fruit/veg/day Y N, Meat/bean/day Y N, Bread/cereal/day Y N

Concerns_____

Elimination

BM Freq/Day_____, Enuresis Y N

Concerns_____

Sleep

Hours/noc_____, Feel fatigued Y N, Nightmares Y N

Concerns_____

Growth and Development

Active in sports Y N, All self-care Y N, Male/female friends Y N,

Ejaculation Y N, Menarche Y N, Cramps Y N, LMP_____

Concerns_____

Current Safety Practices

Seat belt Y N, Water safety Y N, Bike safety Y N, CPR Y N,

Helmet use Y N, Street safety Y N, Firearms Y N, 911 Y N

Behavior/Personality/Interaction

Describe Self _____

Feel good about self Y N, Get along with family Y N,

Independent Y N, Confident Y N, Enjoys peers Y N

Number of friends_____ Boyfriend / Girlfriend Y N

Support person(s)_____

Discipline: reasons for _____

Method used _____

Discipline/rules/responsibility/reasonable? Y N_____

Self/friends smoking Y N, Self/friends drinking-drugs Y N,

Self/friends sexually active Y N, Self/friends in gangs Y N

Respect for others Y N, Amt of TV / video / 24hrs_____

Concerns_____

School

Grade___, Where _____, Days missed/mo.____

Enjoys? Y N, Doing well Y N, Typical grades_____

Favorite subj_____, Least favorite_____,

Extracircular activities_____

Concerns_____

Family Social / Health History

Family Members_____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who?_____

EtOH/drugs Y N Who?_____Illness Y N_____

Concerns _____

Review of Systems (circle positive findings)		Physical Exam (check ☐ if WNL)	
fever, illness, hospitalization, injury	General		☐
swelling, rash, seborrhea, asymmetry, loss of hair	Head		☐
discharge, redness, strabismus, tearing	Eyes		☐
rubbing, irritability, suspicion of infection, discharge	Ears		☐
S/S URI, allergy, rhinorrhea, bleeding	Nose		☐
caries, abcess, swelling of gums/teeth, oral lesion	Mouth		☐
rash, dry skin, moles,birth marks,warts,lesions, acne	Skin		☐
inc. nodes, limited ROM, sore throat, Hx strep	Neck/Throat		☐
cough, wheeze, retractions, flaring, Tb history	Chest	Tanner #	☐
Hx murmur, cyanosis, exercise intolerance	Cardio		☐
food allergy, diarrhea, constipation, emesis, pain	Abdomen		☐
rash, pus or hematuria, dysuria, freq., discharge	Genitalia	Tanner #	☐
limited ROM, change in gait/strength, Fx	Mus/Skel		☐
tremors, lethargy, irritability, seizures,headache LOC	Neuro		☐

PEDIATRIC 10-13 YEAR WCC

Assessment/Dx	Problem List
	1. Health Care Maintenance
	2.
	3.
	4.

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA _____ ☐ PPD _____ ☐ Tine _____
☐ DDST _____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR # ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ STD/Pregnancy prevention ☐ Hazards of alcohol/drugs ☐ Gang/violence ☐ Water/swimming
☐ Fire/cooking ☐ Firearms ☐ Seat belt ☐ Helmet use ☐ Street safety ☐ 911
Other _____

G & D ☐ Sexual development/identity ☐ Conflict resolution ☐ Peer influence ☐ Family interaction
☐ Reading versus TV ☐ Limit TV / video ☐ Importance of schoolwork
☐ Need for regular P.E. ☐ Increased responsibility ☐ Self-care responsibility
Other _____

Nutrition ☐ Encourage variety of foods ☐ Weight mgmt. ☐ Need for breakfast ☐ Exercise vs. diet
☐ Limit fast foods ☐ Limit sweets ☐ Nutritious snacks ☐ Regular dental care
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

Content by Pat Jackson, Design by Steve Elias

Provider Signature _____

PEDIATRIC ≥ 15 yr WCC

Child's Name _____ Date _____ Age _____

Wt _____ (th%), Ht _____ (th%), BP _____, T _____, HR _____, RR _____

Reason for Visit / Concerns _____

Interval History

_____

_____

_____

Injuries? _____

Diet

Satisfied with weight Y N, Food allergies N Y _____

Reg break. Y N, Sweets/day Y N, Fast foods/week _____

Fruit/veg/day Y N, Meat/bean/day Y N, Bread/cereal/day Y N

Concerns _____

Elimination

BM Freq/Day _____, Enuresis Y N

Concerns _____

Sleep

Hours/noc _____, Feel fatigued Y N, Nightmares Y N

Concerns _____

Growth and Development

Active in sports Y N, All self-care Y N, Male/female friends Y N,

Ejaculation Y N, Menarche Y N, Cramps Y N, LMP _____

Concerns _____

Current Safety Practices

Seat belt Y N, Safe sex Y N, Water safety Y N, CPR Y N,

Helmet use Y N, Driving and Alcohol Y N, Firearms Y N,

Behavior/Personality/Interaction

Describe Self _____

Feel good about self Y N, Get along with family Y N,

Independent Y N, Confident Y N, Enjoys peers Y N

Number of friends _____ Boyfriend / Girlfriend Y N

Support person(s) _____

Discipline: reasons for _____

Method used _____

Discipline/rules/responsibility/reasonable? Y N _____

Self/friends smoking Y N, Self/friends drinking-drugs Y N,

Self/friends sexually active Y N, Self/friends in gangs Y N

Respect for others Y N, Amt of TV / video / 24hrs _____

Concerns _____

School

Grade ___, Where _____, Days missed/mo. _____

Enjoys? Y N, Doing well Y N, Typical grades _____

Favorite subj _____, Least favorite _____

Extracircular activities _____

Concerns _____

Family Social / Health History

Family Members _____

Acceptable Housing Y N, Safe Neighborhood Y N

Regular health care Y N Smoking Y N Who? _____

EtOH/drugs Y N Who? _____ Illness Y N _____

Concerns _____

Review of Systems (circle positive findings)	Physical Exam (check if WNL)	
fever, illness, hospitalization, injury	General	
swelling, rash, seborrhea, asymmetry, loss of hair	Head	
discharge, redness, strabismus, tearing	Eyes	
rubbing; irritability, suspicion of infection, discharge	Ears	
S/S URI, allergy, rhinorrhea, bleeding	Nose	
caries, abcess, swelling of gums/teeth, oral lesion	Mouth	
rash, dry skin, moles,birth marks,warts lesions, acne	Skin	
inc. nodes, limited ROM, sore throat, Hx strep	Neck/Throat	
cough, wheeze, retractions, flaring, Tb history	Chest	Tanner #
Hx murmur, cyanosis, exercise intolerance	Cardio	
food allergy, diarrhea, constipation, emesis, pain	Abdomen	
rash, pus or hematuria, dysuria, freq., discharge	Genitalia	Tanner #
limited ROM, change in gait/strength, Fx	Mus/Skel	
tremors, lethargy, irritability, seizures,headache LOC	Neuro	

PEDIATRIC ≥ 13 yr WCC

Assessment/Dx

Problem List

1. Health Care Maintenance
2.
3.
4.

Plan

1. Health Care Maintenance:

Screening Tests: ☐ Hct/Hg _____ ☐ Lead _____ ☐ UA _____ ☐ PPD _____ ☐ Tine _____
☐ DDST _____ ☐ Vision: R _____ L _____ ☐ Hearing: R _____ L _____

Immunizations ☐ Up to Date ☐ DTP # ___ ☐ DTaP # ___ ☐ DTP/Hib # ___ ☐ Hib # ___
☐ OPV # ___ ☐ IPV # ___ ☐ Hep B # ___ ☐ MMR# ___ ☐ _____
☐ Education Risk vs Benefit ☐ Consent Given ☐ Tylenol given ☐ Fever mgt. discussed
☐ Symptoms needing follow-up ☐ Schedule next immun.
Other _____

Safety ☐ STD/Pregnancy prevention ☐ Hazards of alcohol/drugs ☐ Gang/violence ☐ Water/swimming
☐ Fire/cooking ☐ Firearms ☐ Seat belt ☐ Helmet use ☐ Street safety ☐ 911
Other _____

G & D ☐ Sexual development/identity ☐ Conflict resolution ☐ Peer influence ☐ Family interaction
☐ Reading versus TV ☐ Limit TV / video ☐ Importance of schoolwork
☐ Need for regular P.E. ☐ Increased responsibility ☐ Self-care responsibility
Other _____

Nutrition ☐ Encourage variety of foods ☐ Weight mgmt. ☐ Need for breakfast ☐ Exercise vs. diet
☐ Limit fast foods ☐ Limit sweets ☐ Nutritious snacks ☐ Regular dental care
Other _____

HCM Follow-up _____

2. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

3. Diagnostic _____
Therapuetic _____
Patient Ed. _____
Follow-up _____

Narrative _____

Content by Pat Jackson, Design by Steve Elias

Provider Signature _____