Lake Oswego Psychiatric Associates
4000 Kruse Way Place, Bldg 2, Suite 200
Lake Oswego, OR 97035
503 635 9336

Pre-Appointment Health Report for Children and Adolescents

In order that we may address those health concerns most important to you while also maintaining an awareness of your child's overall health status, we invite you to share this information with us at each appointment. You can download this form from our website, LakeOswegoPsychiatric.com and bring it to your appointment, or come a few minutes early to complete it in the waiting room, or complete it in the first few minutes of your appointment.

Please be as precise as possible. Thank you for allowing us to be your partners in your child's optimum health creation and maintenance.

My **main concern** for my child today is _____

I want to make sure that we discuss_____

Since my child's last appointment she or he has had the following **issues**:

Feelings
___anxious
___depressed
___feeling unsafe at home
___feeling unsafe at school
___irritable

Thoughts
___ of hurting herself or himself
___of hurting other people
___difficulty concentrating
___difficulty with memory
___racing thoughts
___odd thoughts

Behavior
___insomnia
___eating too much
___eating too little
___risky behavior
___aggressive

Other symptoms that I feel are important._____

My child's **healthy habits** include the following: (circle no if she or he hasn't developed these habits yet)
Exercise (what form, how long, and how often)_____YES NO
Adequate sleep (time to bed and time awakening, including any naps).
_____YES NO
Eating ____ servings of fruit/day and ____servings of vegetables/day.
We belong to a social, service, or religious group(s). (Please list) YES NO
_____
Spending ____ hrs/week in recreation or hobbies. (please list)_____
Current height is _____. Current weight is _____.

My child's **current physical health** includes problems with the following: (please describe the problem)

Head
Ears, eyes, nose, throat
Thyroid,
Breathing
Heart
Blood Pressure
Digestion and elimination
Kidneys
Reproductive system
Muscles
Joints
Endocrine (diabetes, hormonal, etc)
Lipids, cholesterol, triglycerides
Immune system
Nervous System
Blood System
Allergies (please list)_____
_____

My child's **current medications, remedies, supplements and vitamins** include the following:
Please indicate which doctor is prescribing each.
_____
My address is the same as my last appointment YES NO
new address _____

My phone numbers are the same as my last appointment YES NO
New numbers _____

My insurance is the same as my last appointment YES NO
My new insurance is _____
(Please let us make a copy of your new card)

Thank you for helping us gather this information quickly and efficiently, which will allow us to spend our time together focusing on your goals.

_____ _____
Parent signature and date Physician signature and date

Please complete both sides of this report.