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Pediatric Wellness Update

Patient_____ **Date of Birth**_____ **Today's Date** _____

Does the patient experience any of these symptoms?	*Yes*	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Water Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often does the patient experience these symptoms?

☐ Occasionally (2-3 times per year)

☐ Over 3 times per year

☐ A few long periods of time per year (Spring, Summer, Fall, Winter)

☐ Most of the year

Does the patient take prescription or over-the-counter (OTC) medications for the management of his/her allergy symptoms? ☐ **Yes** ☐ **No**
If yes, name of medication and last date taken:_____

Please indicate below symptoms/conditions the patient experienced during the last 1-2 years	
☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)	☐ Restless sleep, challenges sleeping through the night, snoring
☐ Re-occuring Seasonal Colds	☐ Consistent or Re-occurring coughing
☐ Chronic colds (lasting longer than 2 months)	☐ Feeling of fatigue, irritability, & restlessness
☐ Headaches	☐Asthma
	☐ Skin conditions (dry and/or itchy skin, etc...)

	Yes	No
Would you like to find out what you are allergic to in order for us to help you better control your allergy symptoms?		
Would you be interested in learning more about other treatment options available such as Immunotherapy (Allergy Shots)?		

Parent Name (Print):_____ **Phone:**_____

Parent Signature:_____ **Date:**_____

FOR CAT/CAS USE ONLY- Date of Last ENT Exam:_____

Provider Signature:_____

A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

TeenScreen® Primary Care

Name _____ Clinician _____

DATE OF BIRTH: _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY **Score** _____

Q. 12 and Q. 13 = Y or TS = ≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and colleagues)