

**NANCY'S PREVENTION CLINIC
PEDIATRIC FOLLOW UP**

Name:	Medication Allergies:	Date:
DOB: Age: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	Pediatrician:	
Presenting Complaint: <input type="checkbox"/> Easily Frustrated <input type="checkbox"/> Hearing Voices <input type="checkbox"/> Mood Swings <input type="checkbox"/> Crying Easily <input type="checkbox"/> Fears/Phobias <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Frustration <input type="checkbox"/> Alcohol <input type="checkbox"/> Nicotine <input type="checkbox"/> Caffeine <input type="checkbox"/> Amphetamines <input type="checkbox"/> Other _____		
Please Self Assess Your Of Improvement Since Your First Visit: <input type="checkbox"/> No Improvement <input type="checkbox"/> Slightly Improved <input type="checkbox"/> Moderately Improved <input type="checkbox"/> Greatly Improved <input type="checkbox"/> Feeling "Normal"		

Symptoms: Please comment briefly. Complete every line.

- Sleep _____
- Appetite _____
- Crying Often and Easily _____
- Easily Frustrated /Demands Must Be Met Immediately _____
- Inattentive/Easily Distracted _____
- Restless/ Overactive/ Fidgeting _____
- Mood Changes Quickly and Drastically _____
- Fails to Finish Things that He or She Starts _____
- Actions That He or She Cannot Stop Doing _____
- Excitable/ Impulsive (Acts Without Thinking) _____
- Disturbs Other Children _____
- Risk Taking / Starts Fires _____
- Hurts Himself/ Herself (Bangs His/Her Head or Threatens to Hurt Others) _____
- Unfounded Fears or Phobias _____
- Hallucination (Hearing voices, Seeing visions) _____
- Stressors _____

Give any comments about your child that may be helpful to the provider:

Signature of parent/guardian _____ **Date** _____

<input type="checkbox"/> Nancy Bryant, FNP-C	Patient's Name:
<input type="checkbox"/>	Date: