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Dear Parent or Guardian:

Thank you for bringing your child for a well visit today. We recommend regular well visits (also known as preventive exams or physicals) based on the American Academy of Pediatrics guidelines. We are providing this document to help you understand the difference between what is covered within a well visit versus a problem-oriented visit.

Screening – During well visits we perform recommended screenings appropriate to your child's age and seek to uncover any conditions that may lead to suboptimal health in the years to come. These screenings are also required for school, sports, camp, scouts and other activities. In our experience, some insurance plans cover these screenings and some do not. Because there are so many different insurance companies and plans, we do not know in advance what will and will not be covered. It is your responsibility to understand what screening services are covered by your insurance plan.

Insurance Coverage for Well Visits vs. Problem-Oriented Visits - Well visits may uncover or revisit problem-oriented issues that require evaluation or management (ex. ear infection, allergies, warts). When possible, we strive to address such problem-oriented issues at the same office visit. This is also an additional convenience so that families do not have to return to the office for another appointment. In compliance with insurance company billing policies, these issues then prompt charges for both categories. While preventive services may not require a co-pay/deductible, problem-oriented services do prompt a co-pay/co-insurance/deductible.

If you need further explanation about incurring additional fees for services provided during your visit today, please ask to speak with our biller.

Acknowledgement of Wellness Services Billing Procedures
I acknowledge that during my well visit, there may be a problem-oriented service performed in addition to the wellness services. In this case, I understand that two separate charges may be submitted to my insurance company and that, when applicable, a co-pay/deductible/co-insurance may be required for charges generated pertaining to problem-oriented services. Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my co-pay/deductible would still apply.

Patient name: _____ DOB: _____

Parent/guardian signature: _____ Date: _____

Tuberculosis and Lead Screening Questions

Casa Verde Pediatrics, Inc.

Name of Child _____ DOB _____ Date _____

Tuberculosis (TB) is an infection of the lungs and many other parts of the body that can cause death if undetected and untreated. It is contagious. California wants to treat and protect children who have been exposed to TB and are at risk of the infection.

The following questions help determine testing for tuberculosis. These questions and TB testing are required for childcare, school, and many jobs. These questions are used only to decide who needs TB testing.

Ask the doctor or nurse practitioner if you need more information to answer the questions.

Where was the child born? ***Please circle one***

United States	Northern/Western Europe
Africa	Eastern Europe
Asia	New Zealand/Australia
Middle East	Latin American: Central or South America

Please answer the following questions by circling **yes** or **no**

1. **Has the child traveled to or lived in a country with a high rate of TB and stayed for *one month* or more? YES/NO**

   Where did they travel or live? ***Please circle all areas below***

Africa	Eastern Europe
Asia	New Zealand/Australia
Middle East	Latin American: Central or South America
Northern/Western Europe	

2. **Has the child even been around anyone who has ever had TB or a positive TB test? YES/NO**

This includes anyone with a positive TB test or was treated for TB at any time in the past including family, friends, nannies, babysitters and childcare providers, especially if they were born outside of the United States.

3. **Is your child being treated for a condition that suppresses the immune system? YES/NO**
   This includes: oral steroids for more than a month, infection with HIV, an organ transplant or other medications that suppress the immune system.

For **children under 5**, please continue to the following lead screening questions:

5. Does your child live in or regularly visit a house that was built before 1950? YES NO
Is there chipped, peeling or damaged paint? YES NO
6. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the past 6 months?) YES NO
7. Does your child have a sibling or playmate who has or did have lead poisoning? YES NO

Reviewed on: _____ _____ _____ _____ _____

Staying Healthy Assessment

1 –2 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

1	Do you breastfeed your child?	Yes	No	Skip	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
7	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
8	Are you concerned about your child's weight?	No	Yes	Skip	
9	Does your child watch TV or play video games?	No	Yes	Skip	
10	Does your home have a working smoke detector?	Yes	No	Skip	Safety
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

Please fill out the following about how your child **usually** is. Please try to answer every question
If the behavior is rare (e.g., you've seen it once or twice), please answer as the child does not do it.

Date:

M-CHAT

Age: mo mo

1. Does your child enjoy being swung, bounced on your knee etc.?	Yes	No	Yes	No
2. Does your child take interst in other children?	Yes	No	Yes	No
3. Does your child like climbing on things, such as up stairs?	Yes	No	Yes	No
4. Does your child enjoy playing peek-a-boo/ hide-and-seek?	Yes	No	Yes	No
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	Yes	No	Yes	No
6. Does your child ever use his/her index finger to point, ask for something?	Yes	No	Yes	No
7. Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No	Yes	No
8. Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or drooping them?	Yes	No	Yes	No
9. Does your child ever bring objects over to you (parent) to show you something?	Yes	No	Yes	No
10. Does your child look you in the eye for more than a second or two?	Yes	No	Yes	No
11. Does your child ever seem oversensitive to noise? (e.g. plugging ears)	Yes	No	Yes	No
12. Does your child smile in response to your face or your smile?	Yes	No	Yes	No
13. Does your child imitate you? (e.g., you make face-will your child imitate it?)	Yes	No	Yes	No
14. Does your child respond to his/her name when you call?	Yes	No	Yes	No
15. If you point at a toy across the room, does your child look at it?	Yes	No	Yes	No
16. Does your child walk?	Yes	No	Yes	No
17. Does your child look at things you are looking at?	Yes	No	Yes	No
18. Does your child make unusual finger movements near his/her face?	Yes	No	Yes	No
19. Does your child try to attract y(your attention to his/her own activity?	Yes	No	Yes	No
20. Have you ever wondered if your child is deaf?	Yes	No	Yes	No
21. Does your child understand what people say?	Yes	No	Yes	No
22. Does your child sometimes stare at nothing or wander with no purpose?	Yes	No	Yes	No
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No	Yes	No

1999 Diana Robins, Deborah Fein, & Marianne Barton

Casa Verde Pediatrics, Inc.

ORAL HEALTH and FLUORIDE VARNISH PROGRAM

Name of child: _____ Date of Birth: _____

Parent/Guardian's name: _____

(Please print)

Has your child seen the dentist? Yes _____ No _____

Do you brush your child's teeth at bedtime? Yes _____ No _____

Does your child nurse at night or have a bottle? Yes _____ No _____

Does your child drink juice? Yes _____ No _____

Does your child drink bottled water? Yes _____ No _____

If your family drinks bottled water, is it fluoridated? Yes _____ No _____ I don't know____

A preventive dental program is available for children with risk factors. A protective coating called fluoride varnish can be applied to your child's teeth to prevent tooth decay.

To receive these services you must provide consent.

___ Yes, I want my child to receive fluoride varnish (please fill in the bottom of this form)

___ No, I do not want my child to receive these preventive fluoride varnish services.

HEALTH HISTORY

Has your child ever had serious health problems? No: ___ Yes: ___ If yes, please explain:

_____

Does your child have any allergies? No: ___ Yes: ___ If yes, please list:

_____

Parent Signature: _____ Date: _____

*** This service does not replace a comprehensive evaluation.
We recommend that a dentist regularly examine your child. ***

FOR OFFICE USE ONLY

Comments _____

Varnish placed on: _____ by: _____

Varnish deferred on: _____ ☐ no risk factors

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:	Please check "Yes" where apply. ☑
1. Has your child ever lived with a parent/caregiver who went to jail/prison?	☐
2. Do you think your child ever felt unsupported, unloved and/or unprotected?	☐
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	☐
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?	☐
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	☐
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*	☐
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? Or has any adult in the household ever hit your child so hard that your child had marks or was injured? Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	☐
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*	☐
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	☐

How many "Yes" did you answer in Part 1?: ☐

Please continue to the other side for the rest of questionnaire →

CENTER for YOUTH WELLNESS

UCSF Benioff Children's Hospital Oakland

This tool was created in partnership with UCSF School of Medicine.

PART 2:	Please check "Yes" where apply.	√
1.	Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐
2.	Has your child experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐
3.	Has your child ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐
4.	Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?	☐
5.	Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	☐
6.	Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	☐
7.	Has your child ever lived with a parent or caregiver who died?	☐

How many "Yes" did you answer in Part 2?: ☐

ASQ-3 Ages & Stages Questionnaires®

23 months 0 days through 25 months 15 days

24 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Child ID #:

Program ID #:

Program name:

E101240100

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24 Month Questionnaire

23 months 0 days through 25 months 15 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your showing him, does your child *point* to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(She needs to identify only one picture correctly.)*	○	○	○	___
2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? *(Mark "yes" even if her words are difficult to understand.)*	○	○	○	___
3. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	○	○	○	___

- ○ a. "Put the toy on the table."
- ○ b. "Close the door."
- ○ c. "Bring me a towel."
- ○ d. "Find your coat."
- ○ e. "Take my hand."
- ○ f. "Get your book."

4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	○	○	○	___
5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? *(Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")* Please give an example of your child's word combinations:	○	○	○	___

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COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	○	○	○	___
2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)*	○	○	○	___
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.	○	○	○	___
4. Does your child run fairly well, stopping herself without bumping into things or falling?	○	○	○	___
5. Does your child jump with both feet leaving the floor at the same time?	○	○	○	___
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	○	○	○	___*

GROSS MOTOR TOTAL ___

**If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

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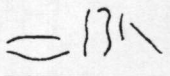
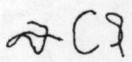
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	○	○	○	___
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	○	○	○	___
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	___
4. Does your child flip switches off and on?	○	○	○	___
5. Does your child stack seven small blocks or toys on top of each other by herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	○	○	○	___
			FINE MOTOR TOTAL	___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in *any direction*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	○	○	○	___
2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? *(Do not show him how.) (You can use a soda-pop bottle or baby bottle.)*	○	○	○	___
3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?	○	○	○	___
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?	○	○	○	___
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___

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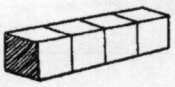
PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	○	○	○	___
			PROBLEM SOLVING TOTAL	___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	___
2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	___
3. Does your child eat with a fork?	○	○	○	___
4. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?	○	○	○	___
5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?	○	○	○	___
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."	○	○	○	___
			PERSONAL-SOCIAL TOTAL	___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ○ YES ○ NO

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OVERALL *(continued)*

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ○ YES ○ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

6. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

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OVERALL *(continued)*

8. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

9. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

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