Small Steps to Health Visit

Adapted with permission from Odessa Brown Children's Clinic 7/05

OBCC Clinic

Date: / /

☐ Acute visit ☐ Planned Visit

Data Entry Note:

Language: ______ Interpreter: ☐ Yes ☐ No

☐ Well Child Visit Survey

Ht: ____ in. Wt: ____ lbs.

BMI: ____ BMI%ile: ____ T: ____ BP: ____

History

CLINICAL DATA

WCC last 12 months? ☐ Yes ☐ No

ROS:	**HEALTH HABITS**	
Headache	Breakfast	d/wk
Dev Delay	Fruit/Veg	x/d
Sleep/Snoring	TV/computer	hrs/d
Cough, Wheeze	Phys Activity	hrs/d
Depression/fatigue	Soda	can/d
Knee/Hip pain/Limp	Juice/Sweetened Beverage	oz/d
Abd pain/Vomiting	Family Meal	d/wk
Oligo/Dysmenorrhea	Lowfat Milk	Y N
	Meals/snacks	B S L S D S

READINESS TO CHANGE

Child low------><------med------><------high 0 1 2 3 4 5 6 7 8 9 10

Adult low------><------med------><------high 0 1 2 3 4 5 6 7 8 9 10

LABS

Fasting glucose/lipids

CBC LFT's TSH/T4

Hgba1c Xray

Comorbidities/Medications

	Current Goal(s):	New Goal(s) today:
Goal/Step # 1		☐ Small Steps to Health Worksheet
Goal/Step # 2		☐ Small Steps to Health Worksheet

Physical Exam

- ☐ Gen: WD/WN NAD, not dysmorphic
- ☐ MS: Nl affect/interaction
- ☐ HEENT:Nl conjunctiva, Nl sclera, EOMI; no papilledema; nares: clear; Nl oral mucosa w/no lesions
- ☐ Neck: supple, FROM, Nl thryoid
- ☐ Chest: Nl BS, CTA B, no wheezes, no rales
- ☐ Abd: soft, Nl bowel sounds; NT/ND; no HSM, no masses
- ☐ Neuro: CN I-IX intact, Nl gait, Nl coordination, Nl DTR's
- ☐ Skin: warm, dry, intact. No cyanosis, clubbing or edema; No straie/hirsutism; no acanthosis nigricans
- ☐ CV: RRR, no murmurs, rubs, gallops
- ☐ Ext: Nl ROM, Nl strength, Nl pulses
- ☐ GU: Tanner ________, Nl ext genitalia

Impression and Plan

Assessment:

1. ☐ Overweight (≥ 95%ile)
   ☐ At Risk of Overweight (85-94%ile)
   ☐ Healthy Weight (< 85%ile)
2. ☐ Accelerated weight gain/BMI%ile
   ☐ Stable growth

Advice:

☐ Nutrition: breakfast, fruit/vegetables, soda/juice

☐ Physical Activity: TV/computer, Physical Activity

Referrals:

☐ Nutrition ☐ Physical Activity: ________________

☐ Mental Health ☐ Other: ________________

☐ Self Management Support

Small Steps follow-up in ☐ wks/mos with ☐ ________ OR ☐ ________ (Provider Name)

Signature: ________________

Well Child Visit follow-up in ☐ months with ________ (Provider Name)

Place Patient Stamp Here

revised 8/1/06