

**WELL CHILD EXAM  
ADOLESCENCE:  
15 – 18 Year**

Michigan Department of Human Services

Authority: P.A. 116 of 1973  
Completion: Required  
Consequences of non-completion:  
Non-compliance of licensing rules.

Well Exam Date		Patient Name		DOB	Sex	Parent/Guardian Name	
Allergies				Current Medications			
Prenatal/Family History							

Weight	Percentile	Height	Percentile	BMI	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

**Interval History:**  
(Include injury/illness, visits to other health care providers, changes in family or home)

**Nutrition**

Grains \_\_\_\_\_ servings per day

Fruit/Vegetables \_\_\_\_\_ servings per day

Whole Milk \_\_\_\_\_ servings per day

Meat/Beans \_\_\_\_\_ servings per day

City water     Well water     Bottled Water

**Elimination**     Normal     Abnormal

**Exercise Assessment**

Physical Activity \_\_\_\_\_ minutes per day

**Sleep**     Normal     Abnormal

**Menstrual**

Premenarchal     Normal     Abnormal

Additional area for comments on page 2

**Screening and Procedures**

Urinalysis (Required for Medicaid sexually active adolescent males and females)

**Hearing**

Parental observation/concerns

**Vision**

Visual acuity (at 15 & 18 years)

\_\_\_\_\_ R    \_\_\_\_\_ L    \_\_\_\_\_ Both

Parental observation/concerns

**Developmental Surveillance**

Social-Emotional     Communicative

Cognitive     Physical Development

**Psychosocial/Behavioral Assessment**

Yes     No

**Alcohol & Drug Use (risk assessment)**

Yes     No

**Screening for Abuse**     Yes     No

**Screen If Risk:**

IPPD \_\_\_\_\_ (result)

Hct or Hgb \_\_\_\_\_ (result)

Dyslipidemia \_\_\_\_\_ (result) (1X 18-20)

STI Screening \_\_\_\_\_ (result)

Cervical Dysplasia \_\_\_\_\_ (result)

Glucose \_\_\_\_\_

**Immunizations:**

Immunizations Reviewed, Given & Charted

*If necessary but not given, document rationale*

Tdap     HPV     Flu     MCV4

MCIR checked/updated

Patient Unclothed     Yes     No

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Normal Growth and Development

Tanner Stage \_\_\_\_\_

Abnormal Findings and Comments

If yes, see additional note area on next page

Results of visit discussed with child/parent

Yes     No

**Plan**

History/Problem List/Meds Updated

Referrals

Children Special Health Care Needs

Transportation

Other \_\_\_\_\_

Other \_\_\_\_\_

**Anticipatory Guidance/Health Education**  
(check if discussed)

**Safety**

Avoid alcohol, tobacco, drugs, inhalants

Make a plan with child if in unsafe situation

Seat belt use for self and passengers

Responsible Driving/follow speed limits

Swimming/Water Safety

Use bike helmet/protective sporting gear

Gun and weapon safety

Learn to protect self from abuse

Limit time in sun-use sunscreen

**Nutrition/physical activity**

Healthy weight/body image/dieting

Limit TV, video, and computer games

Physical activity & adequate sleep

Eat meals as a family

**Oral Health**

Schedule dental appointment

Brush and floss teeth

No smoking/chewing tobacco

**Development and Behavior**

Increased responsibility for own health care

Self breast/Testicular exam

Handling stress & disappointment

Discuss development

Normal sexual feelings

Preventing pregnancy and STIs

Avoid risky or violent situations

Healthy dating relationships

Feeling sad/angry/fearful

Handling depression-suicide

**Family Support and Relationships**

Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression

Know who your teen spends time with

Spend family time together

Home, school, community rules

Respect others

Discuss future plans/college/career

School frustrations/dropping out

Encourage to volunteer/participate with religious, school or community activities

Next Well Check: \_\_\_\_\_ years of age

Developmental Surveillance on Page 2

Page 3 required for Foster Children

Medical Provider Signature: \_\_\_\_\_

**PAGE 2 – WELL CHILD EXAM – ADOLESCENCE: 15 – 20 YEARS  
DEVELOPMENTAL SURVEILLANCE**

(This page may be used if not utilizing a Validated Developmental Screener)

Date	Patient Name	DOB
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**Developmental Questions and Observations**

You may use the following screening list, or an age appropriate standardized developmental instrument or screening tool.

**As the patient to respond to the following statements:**

**Yes    No**

    Please tell me any questions concerns you have today:

- 
- I eat breakfast every day.
  - I am happy with how I am doing in school and/or at work.
  - I have one or more close friends.
  - I feel rested when I wake up.
  - I participate in at least one activity and/or interest other than school and work.
  - I do things with my family.
  - I feel good about my friends and school.
  - I know what to do when I feel angry, stressed, or frustrated.
  - I have someone I can talk to.
  - I have questions about sexuality.
  - I get some physical activity every day.
  - I sometimes feel really down and depressed.
  - I sometimes feel very nervous.

**If the parent is present, ask the parent to respond to the following statements:**

- I am proud of my child.
- I talk to my child about alcohol, drugs, and smoking.
- My child's school work matches his/her future goals.
- My child's school work matches my future goals for him/her.
- I talk to my child about sexuality and our family's values regarding sex.
- I monitor my child's activities and social life.

\*Please note: Formal development examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents)

Additional Notes from pages 1 and 2:

Medical Provider Signature	Medical Provider Name (please print)	
Address		Telephone Number

**THIS PAGE IS REQUIRED FOR FOSTER CARE CHILDREN  
PAGE 3 – WELL CHILD EXAM – ADOLESCENCE: 15 – 18 Years**

Date	Child's Name	DOB
Name of person who accompanied child to appointment	<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent	
Phone number of person who accompanied child to appointment	<input type="checkbox"/> Relative Caregiver (specify relationship) <input type="checkbox"/> Caseworker	

A physical exam, including developmental, psychosocial, and behavioral health screening, must be completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Please attach the completed physical form utilized at this visit.

**Developmental, Psychosocial, and Behavioral Health Screenings (must use validated tool)**

Always ask child, parents and/or guardian if they have concerns about development or behavior. (You must use a standardized behavioral instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services).

Validated Standardized Developmental Screening completed: Date \_\_\_\_\_

Screener Used:    Pediatric Symptom Checklist (PSC)                       Pediatric Symptom Checklist-Youth (PSC-Y)

Other tool (name of tool): \_\_\_\_\_ Score: \_\_\_\_\_

Referral Needed:    No         Yes

Referral Made:    No         Yes        Date of Referral: \_\_\_\_\_ Agency: \_\_\_\_\_

Current or Past Mental Health Services Received:     No             Yes    (if yes please provide name of provider)

Name of Mental Health Provider: \_\_\_\_\_

**EPSDT Abnormal results:**

**Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc.):**

Medical Provider Signature	Medical Provider Name (please print)
Address	Telephone Number

This form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Department of Human Services, Michigan Association of Health Plans, and Michigan Association of Local Public Health.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

## PATIENT/PARENT/CAREGIVER HANDOUT

### Your Child's Health at 15 – 18 Years

#### Milestones

Your development between 15 and 18 years of age.

- You will keep making more decisions for yourself, plan for your life after high school, and discover new skills and talents.
- This can be an exciting time for you but also can be very emotional. This is part of the growing process. You can learn to manage stress or anger by taking a class with a friend or your parents.
- Teens face many tough choices and may feel more pressures to make the wrong choice. This is an important time to talk to friends, parents, family members and trusted teacher to help you learn to make the right choices.

#### For Help or More Information:

##### Safety Information:

Call 1-202-662-0600 or go to <http://www.safekids.org/safety-basics/>

##### Crisis Intervention/Suicide Prevention Information:

- The National Crisis 24/7 Helpline at 1-800-999-9999 or visit <http://www.nineline.org/>
- Girls & Boys Town 24/7 Suicide and Crisis Line: 800-448-3000 or visit [www.girlsandboystown.org/hotline](http://www.girlsandboystown.org/hotline)

##### Sexuality Information for teens:

(Planned Parenthood®) [www.plannedparenthood.org/info-for-teens/index.asp](http://www.plannedparenthood.org/info-for-teens/index.asp)

##### Gambling:

- Michigan Department of Community Health Problem Gambling Help-line: (800) 270-7117 (24-hours)
- National Council on Problem Gambling 24 hour confidential Hotline Number: (800) 522-4700 or online at [www.ncpgambling.org](http://www.ncpgambling.org)

##### AIDS Hotlines:

- Michigan AIDS Hotline (800) 872-2437
- AIDS.GOV website online at [www.aids.gov](http://www.aids.gov)
- National AIDS Hotline: 1-800-CDC-INFO (1-800-232-4636) or online at [www.cdc.gov](http://www.cdc.gov)
- 24-Hour Hotline (Public Health Service): 1-800-342-2437

##### Eating Disorders:

Call the Eating Disorder Hotline 1-800-931-2237 or visit <http://www.mationaleatingdisorders.org/>

##### Domestic Violence hotline:

National Domestic Violence Hotline – (800) 700-SAFE (7233) or online at [www.ndvh.org](http://www.ndvh.org)

##### General information for teens and their parents:

Provides information for teens and parents of teen on many teen topics. <http://www.kidshealth.org/>

## Health Tips

Talk with you doctor at each visit about your health and learn what to do when you have a cold, an earache, or the flu. You should have regular health, vision and dental check-ups.

You need at least 8 hours of sleep each night to do your best at school, work or when driving.

A healthy diet is important. You need certain food to help you grow during your teen years. If you are worried about your weight, check with your doctor. Diet for weight loss should be done only with a doctor or nurse's help. Exercise, healthy foods and fewer snacks are the best way to lose weight. Make a goal to be physically active at least 60 minutes each day. It doesn't have to be all at once. Find activities that you enjoy.

Learn about sexuality, abstinence, sexually transmitted infections and birth control. Be sure you know how and why to say "NO" to sex. Talk to your parents, doctor, nurse or adult advisor about making sexual decisions.

Everyone feels depressed sometimes. It can be serious so see your doctor or find a counselor if you, or someone you know has several of the following signs for more than two weeks:

- Depressed/irritable mood most of the day, nearly every day
- Loss of interest or pleasure in usual activities
- Noticeable change in appetite or weight (when not dieting or trying to gain weight)
- Trouble sleeping or sleeping too much
- Speaking and/or moving with unusual speed or slowness
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive guilt
- Decreased ability to think or concentrate, or unable to make decisions, nearly every day
- Thoughts of death, suicide, wishes to be dead or suicide attempts
- Abusing drugs, alcohol or other substances

## Safety Tips

Use safety equipment, helmets, pads and seat belts.

Driving is most risky for teenagers when they have other teens in the car. You and your parents should agree on clear rules about driving, especially with your friends.

Never drive drunk or ride with anyone who has been drinking. Remember, "Friends don't let friends drive drunk." They also don't let friends ride with a drunk.

Learn gun safety. Never play around with guns. If there are guns or rifles in your home, make sure they are unloaded and locked up.

From the Institute for Health Care Studies at Michigan State University.

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