Patient intake for 4 MONTH HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:
Verbal Sign language Written Assistive Communication Device

Preferred method of learning:
Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:
No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.
If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

Do you suspect your baby is in pain? ◆ **Staff- Evaluate pain with FLACC tool***	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____	(◆ **Staff- Request Records*)**	

Review of Symptoms (Place an "X" in all categories that apply):

Poor weight gain		Fever		Cough	
Hearing concerns		Headache		Wheezing	
Vision concerns		Sinus Congestion Present		Vomiting	
Difficulty Breathing		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in bowel habits		Pulling on Ears		Decreased Appetite	
Sweating with feeds		Ear Drainage		Other:	
Rash		Sore Throat			

Family Screening

Are any members of the household currently deployed or on extended duty outside of the immediate area?	**YES**	**NO**
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	**YES**	**NO**

Nutrition

Feeding Method?

Breast Bottle Spoon Cup Other_____

Feeding Type?

Breastmilk Formula Other: _____

Receiving Vitamin-D supplement daily?

Yes No

Developmental Screen

Smiles on their own or in response to someone?	YES	NOT YET
Holds head steady when held upright?	YES	NOT YET
Coos or babbles?	YES	NOT YET
Elicits attention and likes to play?	YES	NOT YET
Reaches for objects that they want?	YES	NOT YET
Rolls from front onto back?	YES	NOT YET
Uses arms to push chest off surface when on tummy?	YES	NOT YET
Brings things to mouth?	YES	NOT YET

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	**YES**	**NO**

Family history/Surgeries. Check all that apply.

Family History	**Patient** Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
♦To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare?	YES	NO

Please turn the page and complete all EPDS questions. Once you are done, please keep your paperwork with you and wait to be called back.

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition programs.*****

Edinburgh Postnatal Depression Scale (EPDS)

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶ ____

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

(Below for Office Staff)

Weight: _____kg

Length: _____cm

Head Circumference: _____cm

Heart Rate: _____ bpm

Respiratory Rate: _____ breaths/min

O2 sat (if indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

4 Month Health Supervision

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process

Click on me to go to the "**HealthyChildren.org**" Website! An American Academy of Pediatrics (AAP) guide to your child's milestones, growth and development. Search by age.

Your child's growth:

Weight:_____lb. Percentile:_____

Length: _____in. Percentile:_____

Head Circumference:_____cm. Percentile:_____

Parental Well-Being

- Taking care of yourself helps you take care of your baby.
- Call for help if you feel sad or blue

Your Changing Baby

- Put baby to sleep on their back when drowsy at the same time each day for naps and nighttime.
- Encourage active play by offering mirrors and colorful toys to hold.
- Continue tummy time- put your baby on his tummy when awake and you can watch.
- Read to your baby often.

Safety

- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Keep hanging cords or strings away from your baby.
- Keep a hand on your baby when changing clothes or the diaper to prevent falls
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- Do not use a baby walker.

Feeding

- You may begin to feed your baby solid food when your baby is ready.
- Some signs your baby is ready for solids are being able to open mouth for a spoon, sitting with support, good head and neck control, and being interested in foods you eat.

Immunizations

- Pediarix #2 (Hepatitis B, Diptheria, Tetanus, Pertussis, Polio)
- Pedvax #2 (Haemophilus Influenza Type B)
- Prevnar20 #2 (Streptococcal pneumoniae)
- Rotarix oral #2 (Rotavirus)

When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: https://centercitypediatrics.com/wait-worry-panic/

Medications: See attached weight-based Acetaminophen (Tylenol) dosing chart.

Next health supervision appointment: 6 months of age.

Patient specific guidance:

_____

_____

_____