PEDIATRIC ASSESSMENT TOOL

IDENTIFYING DATA:

Client's Initials M ☐ F ☐
Date of Admission
Medical Diagnosis
Age
(Adjust if premature)
Legal Guardian
Historian
Patient's Chief Complaint

GENERAL APPEARANCE:

Weight
Length/Height
Head Circumference
Head/Chest ratio appropriate?
LOC

Vital signs:
BP
Pulse
Temp
Resp
Pain level

PAST HEALTH HISTORY:

Birth History:
Prenatal care Medication used or illness during pregnancy
Gestation:
Method of delivery:
Birth Weight Breast ☐ Bottle ☐
Length of labor and delivery Medications used
Apgar score
Discharged with mother

PAST HISTORY:
Growth and development milestones:
Sit alone
Stand alone
Walk alone
Talk in sentences

Immunization History

Allergies
Disabilities/handicaps
Past Hospitalizations
Childhood illnesses/injuries

Family Health History:

Family Hx of cardiac/renal/liver/diabetes?

OXYGENATION:

Respiratory rate and quality:
Breath sounds
Dyspnea
Oxygen use
Respiratory therapy
Medications used Pulse ox
Lab data

Circulation:
Pulse and blood pressure site
Skin color temperature
Capillary refill
Lab data Medications

Neuro:
LOC
Reflexes
Cranial nerves
PERLA
Fontanels

FLUID AND ELECTROLYTE:

skin turgor
Mucous membranes
Edema
Nausea/diarrhea/vomiting
Change in weight?

Lab data
Medications/IV therapy

NUTRITION:

Usual diet
meals/day
Quality of appetite
Condition of teeth/gums
Dietary supplements

Normal weight current weight

ELIMINATION:

Usual voiding pattern
Incontinent/urgency/frequency/retention
Pain/burning/difficulty voiding

Character of urine
U/A
Medications

usual bowel pattern
Character of stool
Last bowel movement
Constipation/diarrhea/blood in stool
Lab data
Medications

Abdomen:
Soft/firm
Bowel sounds
Bladder palpable
Genitalia/anus
Lab data Medications

ACTIVITY/REST:

Activity status
Sleep habits
Rest routine

ROM
Muscle tone
Posture
Deformity
Tremors
Strength

SAFETY

Skin integrity
Hair condition
Condition-eyes/ears/nose
Breasts/regional lymphatic
Speech/quality of communication
Scars/tattoo/rashes/ulceration/bruising/alterations
Lab data
Medications

SOCIAL INTERACTION: Love and belonging

Home environment
Family support
Lives with
Concerns/stresses
Religion/ethnicity
Primary language

SELF ESTEEM:

Hobbies
School performance
Sexually active
Sexual concerns
Alcohol/smoking/drug use

ERICKSON stage OF DEVELOPMENT

For the adolescent use the **"HEADDS" inquiry tool** to assess psychosocial status:

Home

Education

Activities

Depression

Sex

Reaction to illness/hospitalization: