Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

Pre-Teen Questionnaire
For Pre-Teens (11-12 Years)

Patient Name	Date of Birth	Age

PAST/PRESENT HEALTH CONCERNS (General Health)

What would you like to ask us about your health, your body or your feelings today?

_____

_____

Are you worried about, have or had problems with any of these? *(Circle all that apply)*

Sleep problems - How many hours of sleep do you get? _____	Allergy or nasal symptoms	Constipation	Rashes	Injuries (fractures, sprains, tears)
Appetite / weight	Wheezing or cough	Stomach ache / heartburn	Headaches	Back pain
Energy	Shortness of breath	Bedwetting	Fainting / blackouts / dizziness	Exercise problems
Vision	Chest pain	Urinary symptoms	Head injury / Concussion	Headaches
Hearing	Diarrhea	Acme	Bruising or bleeding easily	Chest pain
			Joint pain or dislocations	Heart racing / skipped beats

Do you think your body is? __Just right __Too fat __Too thin __Too tall __Too short

What would you like to change about your life? _____

SCHOOL

What school do you go to? _____ Grade? _____

What grades do you get? (A's, B's, C's....) _____

What do you do after school? _____

Are you worried about how well you are doing in school?…… Y N

Does your health interfere with school?..... Y N

Parent / Guardian Signature and Date	Provider Signature and Date

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FAMILY

Have any of the following *recently happened* to you or a member of your immediate family?
(Check off any that apply)

__Marriage __Divorce __Given birth __Death __Loss of Job

__Moved away from home __Moved to a new home

Does anyone in your family smoke? ..... Y N

Is anyone in your family chemically dependent, alcoholic, or recovering from drug or alcohol abuse? ..... Y N

How many brothers and sisters do you have? Brothers_____ Ages_____ Sisters_____ Ages_____

Who lives at home with you? (for example brothers, sisters, parents, grandparents, friends, others)

_____

If your parents do not live together (divorced, separated, not married) who do you primarily live with?

_____

How much time do you spend with your other parent? _____

Is there anything that you would like to change about your family?

_____

HABITS/SAFETY

Do you have questions about cigarettes, alcohol, or drugs? …… Y N

Do you feel safe at home? ……..Y N

Do you feel safe at school? ……Y N

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PEDIATRIC SYMPTOM CHECKLIST – Youth Report

Please put an X in the column that best fits you for each question

Pediatric Symptom Checklist	Never	Sometimes	Often
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interested in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other peoples feelings			
32. Tease others			
33. Blame others for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			
Total Score			

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FOR GIRLS ONLY

Have you started having menstrual periods? ……Y N
If yes: How old were you when you had your first period? _____ years.

Any symptoms with your period that concern you? ? ……..Y N

WE HAVE MANY EDUCATIONAL PAMPHLETS AND HANDOUTS IN OUR OFFICE ABOUT HEALTH AND LIFESTYLE ISSUES.

PSC score: (≥28)

Provider initials: _____

Parent / Guardian Signature and Date	Provider Signature and Date