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

11 - 14 Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have any concerns about your child's height or weight?…................................. Y N
2. Does your child get at least 5 servings of fruits/vegetables most days? .... Y N
3. Does your child get less than 2 hours of screen time per day? .... Y N
   (T.V., video games, computer games)
4. Does your child have a TV, VCR, game machine or computer in his/her room? .... Y N
5. Does your child get at least 60 minutes of exercise per day? .... Y N
6. Does your child drink sweetened drinks like pop or juice? .... Y N
7. How many times in a week does your child eat fast-food?___________
8. How many hours a day does your child sleep?
   ___ Less than 8 hours, ___ 8-10 hours, ___ 10-12 hours, ___ more than 12 hours
9. Does he/she seem rested when waking up? .... Y N
10. Has your child been to a dentist this year? .... Y N
11. Do you have any concerns about your child's vision or hearing? .... Y N
12. Has your child had any injuries since last visit? .... Y N

SCHOOL / EDUCATION

13. Do you have any concerns about how your child is doing in school? .... Y N
14. Is your child receiving special education services? .... Y N
15. Does your child read for pleasure? .... Y N

SAFETY

16. Does your child have access to on-line computer service? .... Y N
17. Have you discussed the risks of inappropriate sexual or
    violent material, potential child molester, or harassment ? .... Y N
18. Have you spoken to your child about the risks of tobacco, drugs, alcohol and sex? …. Y N
19. Do you always enforce the use of seatbelts? …... Y N
20. Has your child had swimming lessons? .... Y N
21. Does your child use a helmet when rollerblading, skateboarding or when
    riding a bike, scooter, ATV or snowmobile? .... Y N
22. Does your child consistently use sunscreen? .... Y N
23. Do you have working smoke alarms and carbon monoxide detectors in your home? .. Y N
24. Is there a gun in your home? .... Y N
    If yes, is it locked? .... Y N
25. Does your child feel safe in school, at home, in your neighborhood? .... Y N

Parent / Guardian Signature and Date	Provider Signature and Date

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BEHAVIORAL/SOCIAL

26. Do you have any specific concerns about your child's behavior or emotions? .... Y N
27. Do you feel comfortable with your child's friends? ....Y N
28. Do any of your child's friends use drugs, alcohol or tobacco? ....Y N
29. Are there any new stresses or recent changes impacting your family (job change, move, divorce, illness)? ....Y N

FAMILY MEDICAL HISTORY

30. Has any blood relative on either side of the family had:

(If yes, please write who it is/was)

__ High Cholesterol ____
__ High Blood Pressure ____
__ Heart Disease before age 55 ____
__ Diabetes ____
__ Alcoholism/drug abuse ____
__ Allergies/Hay fever ____
__ Asthma ____
__ Cancer ____
__ Depression / Mental Illness ____
__ Digestive problems ____
__ Kidney problems ____
__ Physical / sexual abuse ____
__ Seizures / Epilepsy ____
__ Sudden death prior to age 40 ____
__ Thyroid problems ____
__ Tobacco use ____

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PEDIATRIC SYMPTOM CHECKLIST (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate how each of these statements best describes your child.

Pediatric Symptom Checklist	Never	Sometimes	Often
1. Feels sad, unhappy			
2. Feels hopeless			
3. Is down on self			
4. Worries a lot			
5. Seems to be having less fun			
6. Fidgety, unable to sit still			
7. Daydreams too much			
8. Distracted easily			
9. Has trouble concentrating			
10. Acts as if driven by a motor			
11. Fights with other children			
12. Does not listen to rules			
13. Does not understand other people's feelings			
14. Teases others			
15. Blames others for his or her troubles			
16. Refuses to share			
17. Takes things that do not belong to him/her			
Total Score			

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TB RISK

1. Does your child live with, or have a greater than once a week contact with an adult with known tuberculosis? .... Y N
2. Did your child, you (parent) or anyone else your child lives with, move in the last five years from anywhere in Asia, Middle East, Africa or Latin America? .... Y N
3. Has your child tested positive for the AIDS virus? .... Y N
4. Is your child exposed on a regular basis (more than twice a week) to anyone infected with AIDS; homeless; in a nursing home, prison or group home; or IV drug user? .... Y N
5. Is your child living in a home with foster children or is he/she a foster child? .... Y N
6. Does your child have any of the following chronic medical problems: diabetes, renal (kidney) failure, or malnutrition? .... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date