

Kiddie West Pediatric Center

4766 W. Broad Street
Columbus, OH 43228
614-851-7337

**15 - 17 Questionnaire
For Parents**

Patient Name	Date of Birth	Age
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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 teen is doing in school? Y N
- 14. Is your child receiving special education services? Y N

SAFETY

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

- 23. Do you have any specific concerns about your teen’s behavior or emotions? Y N
- 24. Do you feel comfortable with your teen’s friends? Y N
- 25. Do any of your teen’s friends use drugs, alcohol or tobacco? Y N
- 26. Do you think your teen is using drugs, alcohol, or tobacco? Y N
- 27. Has your teen ever been in trouble with the law? Y N
- 28. Are you concerned about your teen’s involvement in a romantic relationship? 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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