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

6 - 10 Year Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have any concerns about your child's diet or nutrition? ..... 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 get at least 60 minutes of exercise per day? ..... Y N
5. Does your child drink sweetened drinks like pop or juice? ..... Y N
6. Does your child eat breakfast on a regular basis? ..... 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. Has your child been to a dentist this year? ..... Y N
10. Do you have any concerns about your child's vision or hearing? ..... Y N
11. Has your child had any injuries since last visit? ..... Y N

SCHOOL / EDUCATION

12. Do you have any concerns about how your child is doing in school? ..... Y N
13. Does your child talk to you about what is happening in school? ..... Y N
14. Has your child missed more than 5 days of school? ..... Y N
15. Is your child receiving special education services? ..... Y N
16. Does your child attend before or after school child care? ..... Y N
17. Does your child read for pleasure? ..... Y N

SAFETY

18. Do you have any concerns about your child's friends? ..... Y N
19. Has your child expressed any concerns regarding bullying? ..... Y N
20. Does your child always use a car seat (or booster seat if appropriate)
    in the back seat? ..... Y N
21. Does your child know how to swim? ..... Y N
22. Does your child use a helmet when rollerblading, skateboarding or when
    riding a bike, scooter, ATV or snowmobile? ..... Y N
23. Does your child consistently use sunscreen? ..... Y N
24. Do you have smoke alarms and carbon monoxide detectors in your home? ..... Y N
25. Is there a gun in your home? ..... Y N
    If yes, is it locked? ..... Y N
26. 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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27. Do you have any concerns regarding the use of alcohol or drugs by anyone in contact with your child ? ..... Y N

FAMILYMEDICALHISTORY

28. Is there anyone in your child's family (including extended family) who has high cholesterol, high blood pressure, stroke, early heart disease, diabetes or another chronic illness? ..... Y N

SOCIAL

29. Are there any new stresses or recent changes impacting your family (job change, move, divorce, illness)? ..... Y N
30. Does your child have any emotional or behavior problems for which he/she needs help?..... Y N

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

_____

_____

_____

Parent / Guardian Signature and Date	Provider Signature and Date

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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			

Parent / Guardian Signature and Date	Provider Signature and Date