

Patient & Parent Survey 11-Year-Olds



Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance



Parent Survey

Child's name: _____

Date: _____

General

Does your child bed wet? Yes No

Does your child have bowel accidents? Yes No

Do you have concerns about your child's sleep? Yes No

Does your child snore? Yes No

How many days of school has your child missed this year? _____

How many days of school did your child miss last year? _____

Nutrition and healthy lifestyle

Do you have any worries about your child's diet? Yes No

How worried are you about your child's BMI? Not A little A lot

Does your child:

eat five (or more) servings of fruits/vegetables daily? Yes No

have carbohydrates as the main part of his/her diet? Yes No

eat foods with whole grains and fiber? Yes No

eat three (or more) servings of dairy daily? Yes No

drink sugared soda, juice, or sports drinks regularly? Yes No

eat breakfast daily? Yes No

eat more than two snacks a day? Yes No

eat "fast food" one or more times weekly? Yes No

eat meals together as a family ("family meals")? Yes No

eat after dinner or before bedtime (ie: dessert)? Yes No

get physical activity on a daily basis? Yes No

Would you like some literature on diet for children? Yes No

Safety

Has your child had any injuries this last year? Yes No

Does your child always wear a helmet on a bike, scooter, skateboard, roller blades or skis? Yes No

Is your child in a booster seat (if under 80 pounds/56" tall)? Yes No

Has your child had swimming lessons? Yes No

Has your child been in fights at school? Yes No

Is your child worried about being bullied? Yes No

Has your child ever had issues with lying or stealing? Yes No

Media and on-line safety

Does your child have any of the following:

Cell phone Laptop iPad iPod Touch

Does your child have a TV or internet access in his/her room? Yes No

Do you utilize parental controls? Yes No

What video games does your child play?

Has your child been bullied on-line? Yes No

Is electronic media a source of arguments in house? Yes No

On average, how many hours of "screentime" does your child spend? Weekdays _____ Weekends _____

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Health of family

Who lives with your child? _____

Are there any significant marital, health, financial or employment stresses at home? Yes No

If yes, please explain (if you would like):

Are you:

- Married Partnered Separated Divorced
 Single Widowed Other

How is your health? Poor Fair Good

How is your spouse or partner's health? Poor Fair Good n/a

Do you/your partner have depression or anxiety? Yes No

Has there been any change in employment status (new job or lost job) for you/your partner in the last year? Yes No

Does anyone in your household use tobacco? Yes No

If yes, would you like information on quitting? Yes No

Does anyone in your family have issues with alcohol or drugs? Yes No

Do you feel safe in your own home? Yes No

Learning

Do you have concerns about your child's learning style? Yes No

Is your child on a 504 plan or IEP? Yes No

If yes, are you satisfied with the plan? Yes No

What services does your child receive?

Do you or your child's teacher worry about your child's:

- memory
- handwriting
- attention span
- organizational skill
- spelling
- ability to write stories
- social skills
- ability to express self
- ability to understand written instructions
- ability to understand oral instructions

Has your child had to see a counselor at school? Yes No

Do you feel that your child is exceptionally gifted? Yes No

Perception and parenting

Is your child a worrier? Yes No

Do you feel your child has good self-esteem? Yes No

Have you told your children who your heroes are? Yes No

Do you give your child an allowance? Yes No

Do you give your children responsibilities/chores? Yes No

Health care maintenance

Has your child travelled outside the country this year? Yes No

Has your child been hospitalized or had surgery this year? Yes No

Has your child been to an ER or specialist this year? Yes No

Questions?

Do you have any questions about your child for today's visit?



Pediatric System Checklist

Caregiver completing this form:

Date: -----

Name of child: -----

Please indicate which best fits your child

1. Feels sad, unhappy

Never Sometimes Often

2. Feels hopeless

Never Sometimes Often

3. Is down on him or herself

Never Sometimes Often

4. Worries a lot

Never Sometimes Often

5. Seems to be having less fun

Never Sometimes Often

6. Fidgety, unable to sit still

Never Sometimes Often

7. Daydreams too much

Never Sometimes Often

8. Distracted easily

Never Sometimes Often

9. Has trouble concentrating

Never Sometimes Often

10. Acts as if driven by a motor

Never Sometimes Often

11. Fights with other children

Never Sometimes Often

12. Does not listen to rules

Never Sometimes Often

13. Does not understand other people's feelings

Never Sometimes Often

14. Teases others

Never Sometimes Often

15. Blames others for his or her troubles

Never Sometimes Often

16. Refuses to share

Never Sometimes Often

17. Takes things that do not belong to him or her

Never Sometimes Often

Does your child have any emotional or behavioral problems for which he/she needs help?

Yes No Already receiving help



Kid's Survey

Child's name: _____

Date: _____

Do you have a best friend(s)? Yes No

Do you eat with a friend at lunch? Yes No

Do kids pick on you or tease you? Yes No

Do you hang out with others
on the playground or play alone? Others Alone

Are you happy with your body? Yes No

Do you have a TV in your bedroom? Yes No

Which video games do you play most often?

Do you use text messaging
or instant messaging (IM-ing)? Yes No

Do you have an e-mail account? Yes No

Do you use social media
(Facebook, Twitter, Instagram, etc.)? Yes No

Have you ever been a victim of cyber-bullying? Yes No

Are you happy with school? Yes No

Do you worry about anything? Yes No

Are you in a booster seat? Yes No

Do you always wear a helmet
when riding a bike, scooter, or skiing? Yes No

Do you read for at least 20 minutes a day? Yes No

Do you have any questions for the doctor? Yes No

The following five sentences describe how people feel. Read each phrase and then decide if it is "Not or hardly ever true" or "Sometimes true" or "Very or often true" for you. Then make the selection that best describes you for the past three months.

I get really frightened for no reason at all.
 Not or hardly ever true Sometimes true Very or often true

I am afraid to be alone in the house.
 Not or hardly ever true Sometimes true Very or often true

People tell me that I worry too much.
 Not or hardly ever true Sometimes true Very or often true

I am scared to go to school.
 Not or hardly ever true Sometimes true Very or often true

I am shy.
 Not or hardly ever true Sometimes true Very or often true