Patient & Parent Survey

12-Year-Olds

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Parent Survey

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535

wmpeds.com

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 _____

NEXT PAGE >

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 childtravelled 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?

_____

_____

_____

PHQ-9

Patient Health Questionaire

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535

wmpeds.com

Please have your child complete this survey.

Child's name: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

If you indicated any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❍ Not difficult at all
❍ Somewhat difficult
❍ Very difficult
❍ Extremely difficult

For office coding: ____ + ____ + ____ + ____

= Total score _____

PSC-17

Pediatric System Checklist

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535

wmpeds.com

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

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535
wmpeds.com

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