

Patient & Parent Survey 13-Year-Olds



Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance



Parent Survey

Child's name: _____

Date: _____

General

What are your teenager's strengths?

Has your teenager won any academic, sports, or other awards this past year (including honor roll)? Yes No

If yes, what are they?

Does your child know the important parts of his/her medical history (ie: allergies, medications, etc.)? Yes No

Do you have concerns about your child's sleep? 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/Healthy lifestyle

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

If yes, please elaborate:

Are you worried about your child's BMI? Yes Somewhat No

Does your child:

Eat 5 (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 3 (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 2 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

Social

Does your teen have friends he/she sees regularly? Yes No

Are you concerned your child is being bullied? Yes No

Mental health

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

Has your teenager seen a mental health provider (or school counselor at anytime)? Yes No

Are you concerned your teen might have anxiety? Yes No

Are you concerned your teen might be depressed? Yes No

Has your teen ever considered or attempted suicide? Yes No

Health of family

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

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 house smoke? 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

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Learning

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

What kind of student is your teen?

Poor Average Good Great

Does your teenager like school? Yes No

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

Media/On-line safety

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

Do you monitor the websites your teenager visits? Yes No

Do you utilize parental controls? Yes No

Has your child been bullied on-line? Yes No

Is your teen's phone in their room at night? Yes No

Safety

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

Have you removed old medications from your medicine cabinet (especially pain or anxiety meds)? Yes No

Have you discussed drugs and alcohol with your teen? Yes No

Has a parent discussed sexual health with your teen? Yes No

Health care maintenance

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

Has your teen been hospitalized/had surgery this year? Yes No

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

Are there any subjects you would like us to discuss with your teenager? Please be as specific as you can.

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