Patient & Parent Survey

15-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

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?

_____

_____

_____

PSC-17

Pediatric System Checklist

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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