

# Patient & Parent Survey 18-Year-Olds



**Westwood-Mansfield Pediatrics**  
Boston Children's  
Primary Care Alliance



# Parent Survey

Child's name: \_\_\_\_\_

Date: \_\_\_\_\_

## General

What are your teenager's strengths or passions?

\_\_\_\_\_

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? \_\_\_\_\_

## Learning

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

What kind of student is your teen?

Poor  Average  Good  Great

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

## 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 a referral to a nutritionist?  Yes  No

## Media/On-line safety

Do you monitor your child's on-line life?  Yes  No

Do you utilize parental controls?  Yes  No

Has your child received or sent "sexts"?  Yes  No

Has your child been bullied on-line?  Yes  No

Is your teen's phone in their room at night?  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 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





# Pediatric System Checklist

Caregiver completing this form:

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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