

Child's Name: \_\_\_\_\_

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

**PARENT SURVEY FOR 13 – 15 YEAR OLDS**

**GENERAL**

What are your teenager's strengths? \_\_\_\_\_

Has your teenager won any academic, sports, or other awards this past year (including honor roll)? N Y

If yes, what are they? \_\_\_\_\_

Does your child know the important parts of his/her medical history (ie: allergies, medications, etc...)? N Y

Do you have concerns about your child's sleep? Y N

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? Y N  
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? N Y

have carbohydrates as the main part of his/her diet? Y N

eat foods with whole grains and fiber? N Y

eat 3 (or more) servings of dairy daily? N Y

drink sugared soda, juice, or sports drinks regularly? Y N

eat breakfast daily? N Y

eat more than 2 snacks a day? Y N

eat "fast food" one or more times weekly? Y N

eat meals together as a family ("family meals")? N Y

eat after dinner or before bedtime (ie: dessert)? Y N

get physical activity on a daily basis? N Y

Would you like some literature on diet for children? Y N

**SOCIAL**

Does your teen have friends he/she sees regularly? N Y

Are you concerned your child is being bullied? Y N

**MENTAL HEALTH**

Do you feel your child has good self-esteem? N Y

Has your teenager seen a mental health provider (or school counselor at any time)? Y N

Are you concerned your teen might have anxiety? Y N

Are you concerned your teen might be depressed? Y N

Has your teen ever considered or attempted suicide? Y N

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

\_\_\_\_\_  
\_\_\_\_\_

**HEALTH OF FAMILY**

Are there any significant marital, health, financial or employment stresses at home? Y N

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? Y N

Has there been any change in employment status (new job or lost job) for you/your partner in the last year? Y N

Does anyone in your house smoke? Y N

If yes, would you like information on quitting? Y N

Does anyone in your family have issues with alcohol or drugs? Y N

Do you feel safe in your own home? N Y

**LEARNING**

Do you have concerns about your child's academic performance? Y N

What kind of student is your teen? Poor Average Good Great

Does your teenager like school? N Y

Is your child on a 504 Plan or IEP? Y N

**MEDIA/ON-LINE SAFETY**

Does your child have a TV or internet access in his/her room? Y N

Do you monitor the websites your teenager visits? N Y

Do you utilize parental controls? N Y

Has your child been bullied on-line? Y N

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

**SAFETY**

Has your child had any injuries this last year? Y N

Have you removed old medications from your medicine cabinet (especially pain or anxiety meds)? N Y

Have you discussed drugs and alcohol with your teen? N Y

Has a parent discussed sexual health with your teen? N Y

**HEALTH CARE MAINTENANCE**

Has your teen travelled outside the country this year? Y N

Has your teen been hospitalized/had surgery this year? Y N

Has your child been to an ER or specialist this year? Y N

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

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

If you smoke and want to quit .....1-800-TRY-TO-STOP

If you feel you have an alcohol problem contact Alcoholics Anonymous.....1-800-443-9484

National Suicide Prevention Hotline number.....1-800-273-8255 (program this into your teen's phone)

Remember to check smoke detector/carbon monoxide detector batteries every 6 months.

PLEASE TURN OVER AND COMPLETE BOTH SIDES!!!!





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www.wmpeds.com

### Pediatric System Checklist – 17 (PSC-17)

Caregiver Completing this Form: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

		Please mark under the heading that best fits your child		
		Never	Sometimes	Often
1	Feels sad, unhappy			
2	Feels hopeless			
3	Is down on him or herself			
4	Worries a lot			
5	Seems to be having less fun			
6	Fidgety, unable to sit still			
7	Daydreams too much			
8	Distracted easily			
9	Has trouble concentrating			
10	Acts as if driven by a motor			
11	Fights with other children			
12	Does not listen to rules			
13	Does not understand other people's feelings			
14	Teases others			
15	Blames others for his or her troubles			
16	Refuses to share			
17	Takes things that do not belong to him or her			

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

\_\_\_\_\_ No      \_\_\_\_\_ Yes      \_\_\_\_\_ Already receiving help