Child's Name: _____ Date: _____

PARENT SURVEY FOR AGES 16 - 18

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?) 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? _____

LEARNING

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

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

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

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 a referral to a nutritionist? Y N

MEDIA/ON-LINE SAFETY

Do you monitor your child's on-line life? N Y

Do you utilize parental controls? N Y

Has your child received or sent "sexts"? Y ??? N

Has your child been bullied on-line? Y N

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

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 separated divorced single widowed

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

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

Do you feel safe in your own home? N Y

SAFETY

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

Has your teen ever received a ticket while driving? Y N

Has your teen ever been in an accident while driving? Y N

Have you cleaned out your medicine cabinet of old medications (especially pain/anxiety meds)? N Y

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

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

MENTAL HEALTH

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

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

Are you concerned your child is being bullied? Y N

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

Is there a gun in your house? Y N

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

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?

1. _____
2. _____

If you feel you have an alcohol problem contact Alcoholics Anonymous……1-800-443-9484
If you smoke and want to quit ……..1-800-TRY-TO-STOP
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.

8/16

PLEASE TURN OVER AND COMPLETE BOTH SIDES!!!!

Westwood-Mansfield Pediatric Associates

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Westwood, MA 02090
(781) 326-7700
Fax (781) 251-0910

Mansfield Office
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Fax (508) 452-3898

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115 Main Street
Easton, MA 02356
(508) 535-5535
Fax (508) 238-1315

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