Child's Name: _____ Date: _____

PARENT SURVEY FOR AGES 6-12

GENERAL

What are your child's strengths? _____

_____

Does your child bed wet? Y N

Does your child have bowel accidents? Y N

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

Does your child snore? 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 child's diet? Y N

How worried are you about your child's BMI? Not A little A lot

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

SAFETY

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

Does your child *always* wear a helmet on a bike, scooter, skateboard, rollerblades or skis? N Y

Is your child in a booster seat (if <80 pounds/56" tall)? N Y

Has your child had swimming lessons? N Y

Has your child been in fights at school? Y N

Is your child worried about being bullied? Y N

Has your child ever had issues with lying or stealing? Y N

MEDIA/ON-LINE SAFETY

Does your child have any of the following: cell phone laptop iPAD iPOD Touch

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

Do you utilize parental controls? N Y

What video games does your child play? _____

Has your child been bullied on-line? Y N

Is electronic media a source of arguments in house? Y N

On average, how many hours of "screen time" does your child spend? _____ weekdays _____ weekends

HEALTH OF FAMILY

Who lives with your child? _____

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

Are you: married partnered separated divorced single widowed other

How is your health? poor fair good

How is your spouse or partner's health? n/a poor fair good

Do you/your partner have depression or anxiety? Y N

Have there been any changes in employment status (new job, 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 how to quit? Y N

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

Do you feel safe in your own home? N Y

LEARNING

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

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

If yes, are you satisfied with the plan? N Y

What services does your child receive? _____

Do you or your child's teacher worry about your child's:

memory	handwriting
attention span	organizational skill
spelling	ability to write stories
social skills	ability to express self
ability to understand written instructions	
ability to understand oral instructions	

Has your child had to see a counselor at school? Y N

Do you feel that your child is exceptionally gifted? Y N

PERCEPTION/PARENTING

Is your child a worrier? Y N

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

Have you told your children who your heroes are? N Y

Do you give your child an allowance? N Y

Do you give your children responsibilities/chores? N Y

HEALTH CARE MAINTENANCE

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

Has your child been hospitalized or 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 4/12

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

National Suicide Prevention Hotline number ……1 800-273-8255

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

PLEASE TURN OVER AND COMPLETE BOTH SIDES!!!!

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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

Child's Name: _____ Date: _____

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Kid's Survey (8 to 12 Year Old)

Do you have a best friend(s)?	Yes	No
Do you eat with a friend at lunch?	Yes	No
Do kids pick on you or tease you?	Yes	No
Do you hang out with others on the playground or play alone?	Others	Alone
Are you happy with your body?	Yes	No
Do you have a TV in your bedroom?	Yes	No
Which video games do you play most often? _____		
Do you use text messaging or instant messaging (IM-ing)?	Yes	No
Do you have an e-mail account?	Yes	No
Do you use social media (Facebook, Twitter, Instagram, etc…)?	Yes	No
Have you ever been a victim of cyber-bullying?	Yes	No
Are you happy with school?	Yes	No
Do you worry about anything?	Yes	No
Are you in a booster seat?	Yes	No
Do you always wear a helmet when riding a bike, scooter, or skiing?	Yes	No
Do you read for at least 20 minutes a day?	Yes	No
Do you have any questions for the doctor?	Yes	No

_____

The following 5 sentences describe how people feel. Read each phrase and then decide if it is "Not True / Hardly Ever True" or "Sometimes True / Somewhat True" or "Very True / Often True" for you. Then check the box that best describes you for the past 3 months.

	Not True (Hardly Ever True)	Sometimes True	True (Often True)
I get really frightened for no reason at all.			
I am afraid to be alone in the house.			
People tell me that I worry too much.			
I am scared to go to school.			
I am shy.			

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Patient Health Questionnaire 9 (PHQ-9)

(Please have your child complete this survey)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**

For office coding: ____ + ____ + ____ + ____

= total score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name: _____ Date: _____