

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?**

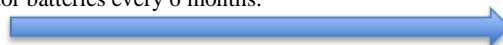
1. \_\_\_\_\_
2. \_\_\_\_\_

**If you smoke and want to quit .....1-800-TRY-TO-STOP**  
**If you feel you have an alcohol problem contact Alcoholics Anonymous.....1-800-443-9484**  
**National Suicide Prevention Hotline number .....1 800-273-8255**

4/12

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

**PLEASE TURN OVER AND COMPLETE BOTH SIDES!!!!**





**Westwood Office**  
 541 High Street  
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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



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[www.wmpeds.com](http://www.wmpeds.com)**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.			