

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?

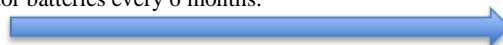
1. _____
2. _____

If you smoke and want to quit1-800-TRY-TO-STOP
If you feel you have an alcohol problem contact Alcoholics Anonymous.....1-800-443-9484
National Suicide Prevention Hotline number1 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
 Westwood, MA 02090
 (781) 326-7700
 Fax (781) 251-0910

Mansfield Office
 454 Chauncy Street
 Mansfield, MA 02048
 (508) 339-9944
 Fax (508) 452-3898

Easton Office
 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



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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.			