Parent / Guardian Questionnaire (7-11 year old)

Pediatric Specialists of the Northwest

Child's name: _____ Date of birth: _____ Date completed: _____

Your name: _____ Relation to child: _____

Check, circle, or complete all which apply to your child

DAILY ACTIVITY and ROUTINE

My child:

Reads	_____ books / week
Writes / draws	**YES** or **NO**
Plays with friends	**YES** or **NO**
Completes all assigned homework	**YES** or **NO**
Screen time (unrelated to homework) (i.e. TV/video games/computer)	_____ hrs/day
Phone/texting/use of social media	_____ hrs/day

Goes to bed **inconsistently** / **consistently** at ___ pm

Gets _____ hours of sleep *on average* each night

Exercise/sports: _____ hr/wk

Specify:

NUTRITION and BOWEL HABITS

Concern about intake of:

Fatty foods?	**TOO MUCH**	**JUST RIGHT**
Salty foods?	**TOO MUCH**	**JUST RIGHT**
Sugary/sweet foods?	**TOO MUCH**	**JUST RIGHT**
Fiber?	**TOO LITTLE**	**TOO MUCH** **JUST RIGHT**

Daily intake:

Dairy (milk, yogurt & cheese)	_____ servings/ day
Meat, poultry, fish, eggs & nuts	_____ servings/ day
Vegetables	_____ servings/ day
Fruits	_____ servings/ day
Bread, cereal, rice & pasta	_____ servings/ day

Supplement: □ vitamin □ iron □ calcium

Soda or pop _____ oz/day **Juice**_____ oz/day

Fast food _____ times/week **Junk food** _____ times/day

Concerns about bowel movements / urination ☐ No ☐ Yes

SCHOOL READINESS

Current grade (or if summer, going into) _____

Services my child receives

□ Repeated any grade □ Special education □ IEP

□ Speech therapy □ OT □ PT

Grades

My child gets: (*check all that apply)*

□ A's □ B's □ C's □ D's □ F's

I *fear* my child has difficulty with:

□ Math □ Reading □ Writing □ Language

Mood, Behavior, & Personality *Check all that apply*

□ Happy	□ Depressed mood	□ Quiet, timid	□ Short Attention	□ Poor Self Control
□ Active	□ Sad	□ Cries easily	□ Distracts easily	□ Initiates physical fight
□ Pays attention	□ Tired, Fatigue	□ Fear New Situation	□ Hyperactive	□ Destruction of property
□ Friendly	□ Thoughts of suicide	□ Mood Swings	□ Impulsive	□ Cruel to people or animals
□ Lies, steals	□ Eating problems	□ Responsible		

□ Speech delay	□ Sleep Problems	□ Stereotypic habit
□ Social communication delay	□ Temper tantrum	Nail Biting, thumb sucking, hair pulling
□ Poor eye to eye contact	□ Separation anxiety	Head banging, body rocking
□ Does not play with other kids	□ Bed wetting	□ Other concern:

Reviewed and discussed by _____, MD/DO Date: _____

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SOCIAL HISTORY

In the past year, have there been any changes or challenges in your family?

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of job
- ☐ Move to a new neighborhood
- ☐ Deaths
- ☐ Births
- ☐ Serious illness
- ☐ Other: _____

_____

- ☐ No interval changes

Does your child live with or spend time with anyone who uses tobacco or smokes?	☐ No	☐ Yes
Does your child play with other children?	☐ Yes	☐ No
Does your child have a best friend?	☐ Yes	☐ No
Does you child say "I'm sorry" for hurting someone's feelings?	☐ Yes	☐ No
Do you have reason to suspect that your child is bullied or bullying?	☐ No	☐ Yes
Do you know what signs to look for if your child is being bullied?	☐ Yes	☐ No
Do new people understand your child's speech?	☐ Yes	☐ No
Is your child becoming more independent?	☐ Yes	☐ No
Would you say that your child handles change or challenges well?	☐ Yes	☐ No

FAMILY HISTORY

Have you or any of your child's relatives developed new medical problems since your last visit?	☐ No	☐ Yes

Tuberculosis Assessment - ***Circle the appropriate response***

1.	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	YES	NO	DON'T KNOW
2.	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	YES	NO	DON'T KNOW
3.	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	YES	NO	DON'T KNOW
4.	Is your child infected with HIV?	YES	NO	DON'T KNOW

If you have additional questions and concerns, please list them on a separate page.

Reviewed and discussed by _____, MD/DO Date: _____