Parent / Guardian Questionnaire (12-17 year old)

Pediatric Specialists of the Northwest

Adolescent's name: ________________________ Date of birth: ______________ Date completed: _____________

Completed by: _________________________________ Relation to adolescent: ______________________________

Check, circle, or complete all of which apply to your adolescent

DAILY ACTIVITY and ROUTINE

Current grade (or if summer, going into) _______

☐ Repeated any grade ☐ Special education ☐ IEP

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

My child:

Reads _______ minutes / day

Socializes with friends **YES** or **NO**

Completes all assigned homework **YES** or **NO**

TV / Video / Movies _______ hrs / day

Plays computer / video games _______ hrs / day

Talks on the phone _______ hrs / day

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

Gets _______ hours of sleep *on average* each night

Exercise / sports: _______ hrs / day

Specify:

NUTRITION and BOWEL HABITS

Daily intake:

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 ☐ Other ___________________

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

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

Concerns about bowel movements / urination ☐ No ☐ Yes

SOCIAL HISTORY

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

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

☐ Other: ____

____

☐ No interval changes

FAMILY HISTORY

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

Reviewed and discussed by ____________________________________, MD/DO Date: ____________________

Parent / Guardian Questionnaire (12-17 year old)

Pediatric Specialists of the Northwest

Adolescent's name: ______________________ Date of birth: ____________ Date completed: ____________

Completed by: ______________________________ Relation to adolescent: ____________________________

Tuberculosis Assessment – Circle the appropriate response			
1. Was your child born in a country/continent at high risk for tuberculosis?	YES	NO	DON'T KNOW
2. Has your child traveled for longer than 1 week to Africa, Asia, Latin America, or Eastern Europe?	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. Does your child spend any time with anyone who has been in jail, uses illegal drugs, or has HIV?	YES	NO	DON'T KNOW

Check all that apply

HOW WOULD YOU BEST DESCRIBE YOUR ADOLESCENT

☐ Happy	☐ Depressed mood	☐ Quiet, Timid	☐ Short attention	☐ Poor self-control
☐ Active	☐ Sad	☐ Cries easily	☐ Distracts easily	☐ Initiates physical fights
☐ Pays attention	☐ Tired, Fatigue	☐ Fears new situations	☐ Hyperactive	☐ Destruction of property
☐ Friendly	☐ Thoughts of suicide	☐ Mood Swings	☐ Impulsive	☐ Cruel to people or animals
☐ Lies, steals	☐ Eating problems	☐ Responsible	☐ Trouble with the law	

☐ Sleep problems	☐ Temper tantrums	☐ Stereotypic habit
☐ Social communication delay	☐ Separation anxiety	Nail biting, thumb sucking, hair pulling
☐ Poor eye to eye contact	☐ Does not play with other kids	Head banging, body rocking
☐ Other concern:		

QUESTIONS & CONCERNS (about your adolescent):

Are you concerned about…

No	Yes		No	Yes	
☐	☐	Physical problems	☐	☐	Physical, sexual, or emotional abuse
☐	☐	Change in appetite or weight	☐	☐	*Lives with* or *carries* a gun, knife, or other weapon
☐	☐	Sleep patterns	☐	☐	Sexually active
☐	☐	Diet / nutrition	☐	☐	Pregnancy
☐	☐	Amount of physical activity	☐	☐	Sexual identity
☐	☐	Relationships with parents / siblings / peers / friends	☐	☐	Use of marijuana or other drugs, tobacco, or alcohol
☐	☐	Self-image	☐	☐	Work or job
☐	☐	Violence or gang activity	☐	☐	Dating / parties your adolescent goes to
☐	☐	Bullying or being bullied			

What seems to be the greatest challenge for your teen?

Other questions or concerns:

1)

2)

3)

Parent / Guardian Signature ______________________________ **Date:** ______________

Reviewed and discussed by ______________________________ **, MD/DO** **Date:** ______________