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 which apply to your child

ACTIVITIES, ROUTINE, and SCHOOL

Current grade _____

□ 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 _____ books / week

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: _____ 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:

Milk, yogurt & cheese	_____ oz/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

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: _____

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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

MOOD, BEHAVIOR, & PERSONALITY Inventory

Check all that describe your adolescent:

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

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

QUESTIONS & CONCERNS (about your adolescent):

Are you concerned about…

No	Yes	
☐	☐	Physical problems
☐	☐	Change in appetite or weight
☐	☐	Sleep patterns
☐	☐	Diet/nutrition
☐	☐	Amount of physical activity
☐	☐	Relationships with parents/siblings/peers/friends
☐	☐	Self image
☐	☐	Violence or gang activity
☐	☐	Bullying or being bullied

No	Yes	
☐	☐	Physical, sexual, or emotional abuse
☐	☐	*Lives with* or *carries* a gun, knife, or other weapon
☐	☐	Sexually active
☐	☐	Pregnancy
☐	☐	Sexual identity
☐	☐	Use of marijuana or other drugs, tobacco, or alcohol
☐	☐	Work or job
☐	☐	Dating / parties your adolescent goes to

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: _____