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 of which apply to your child

DAILY ACTIVITY and ROUTINE

My child:

Reads _____ minutes / day

Writes / draws **YES** or **NO**

Plays with friends **YES** or **NO**

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

Screen time (unrelated to homework) _____ hrs / day

(i.e. TV, video games, computer)

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: _____ hrs / day

Specify:

NUTRITION and BOWEL HABITS

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 ☐ Other _____

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

Check all that apply

HOW WOULD YOU BEST DESCRIBE YOUR CHILD

☐ 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		

☐ Speech delay
☐ Social communication delay
☐ Poor eye to eye contact
☐ Does not play with other kids

☐ Sleep problems
☐ Temper tantrums
☐ Separation anxiety
☐ Bed wetting

☐ Stereotypic habit
Nail biting, thumb sucking, hair pulling
Head banging, body rocking
☐ 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 ☐ Loss of job ☐ Births
☐ Separation ☐ Move to a new neighborhood ☐ Serious illness
☐ Divorce ☐ Deaths
☐ 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 your 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/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

If you have additional questions or concerns, please list them on a separate sheet.

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