Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? ______________________________

Can you describe your child's nutritional habits?

1. Milk:	Whole	Low-fat	Soy	
2. Appetite:	Good	Variable	Picky	
3. Water Source:	City	Well	Spring	Bottled
4. Variety of foods	Fruits	Veggies	Breads	Meats
5. Multivitamin with iron	Yes	No		
6. Eats Breakfast:	Yes	No		
7. Eats supper as family	Yes	No		

Is there any problems with hearing and vision?

1. Do you have concerns about how your child sees? Yes No
2. Has your child failed a school vision test? Yes No
3. Does your child tend to squint? Yes No
4. Do you have concerns about how your child hears? Yes No
5. Do you have concerns about how your child speaks? Yes No

Has there been any foreign travel in the past 60 days or foreign adoption? Yes No

Has there been any exposure to smoking? Yes No Who: __________

Lead Screening (please answer for ages 2 year, 3 year, 4 year, 5 year, and 6 year)

1. Does your child live in or regularly visit a house built before 1950?	Yes	No
2. Does your child live in or regularly visit a house built before 1978 with recent renovations?	Yes	No
3. Does your child have a sibling or playmates that have or have had lead poisoning?	Yes	No
4. Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking?	Yes	No

Immunizations

1.Previous reaction to immunizations	Yes	No
2.Have family members been immunized (mom, dad, sibling)	Yes	No
3.History of chicken pox in child being seen	Yes	No
4.Serious illness at home or relatives (cancer)	Yes	No
5.Allergic to eggs, gelatin, Neomycin, yeast	Yes	No

Please describe your social history.

1.Race: ______________
2.Language: ______________
3.Lives With: ______________
4. Ethnicity: ______________
5. # Siblings: ______________

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes No Specify: ______________________________

Have there been any changes in your child's medical needs?

1.New Problems or illness Yes No Specify: ______________________________
2.Please list current medications (prescription and over-the-counter) ______________________________

Child's Name ________________ Record Number ________________
Today's Date ________________ Filled out by ________________
Date of Birth ________________

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	____	____	____
2.	Spends more time alone	2	____	____	____
3.	Tires easily, has little energy	3	____	____	____
4.	Fidgety, unable to sit still	4	____	____	____
5.	Has trouble with a teacher	5	____	____	____
6.	Less interested in school	6	____	____	____
7.	Acts as if driven by a motor	7	____	____	____
8.	Daydreams too much	8	____	____	____
9.	Distracted easily	9	____	____	____
10.	Is afraid of new situations	10	____	____	____
11.	Feels sad, unhappy	11	____	____	____
12.	Is irritable, angry	12	____	____	____
13.	Feels hopeless	13	____	____	____
14.	Has trouble concentrating	14	____	____	____
15.	Less interest in friends	15	____	____	____
16.	Fights with others	16	____	____	____
17.	Absent from school	17	____	____	____
18.	School grades dropping	18	____	____	____
19.	Is down on him or herself	19	____	____	____
20.	Visits doctor with doctor finding nothing wrong	20	____	____	____
21.	Has trouble sleeping	21	____	____	____
22.	Worries a lot	22	____	____	____
23.	Wants to be with you more than before	23	____	____	____
24.	Feels he or she is bad	24	____	____	____
25.	Takes unnecessary risks	25	____	____	____
26.	Gets hurt frequently	26	____	____	____
27.	Seems to be having less fun	27	____	____	____
28.	Acts younger than children his or her age	28	____	____	____
29.	Does not listen to rules	29	____	____	____
30.	Does not show feelings	30	____	____	____
31.	Does not understand other people's feelings	31	____	____	____
32.	Teases others	32	____	____	____
33.	Blames others for his or her troubles	33	____	____	____
34.	Takes things that do not belong to him or her	34	____	____	____
35.	Refuses to share	35	____	____	____

Total score ________________

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?____

©1988, M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital

Pediatric Symptom Checklist - Youth Report (Y-PSC)

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains	___	___	___
2. Spend more time alone	___	___	___
3. Tire easily, little energy	___	___	___
4. Fidgety, unable to sit still	___	___	___
5. Have trouble with teacher	___	___	___
6. Less interested in school	___	___	___
7. Act as if driven by motor	___	___	___
8. Daydream too much	___	___	___
9. Distract easily	___	___	___
10. Are afraid of new situations	___	___	___
11. Feel sad, unhappy	___	___	___
12. Are irritable, angry	___	___	___
13. Feel hopeless	___	___	___
14. Have trouble concentrating	___	___	___
15. Less interested in friends	___	___	___
16. Fight with other children	___	___	___
17. Absent from school	___	___	___
18. School grades dropping	___	___	___
19. Down on yourself	___	___	___
20. Visit doctor with doctor finding nothing wrong	___	___	___
21. Have trouble sleeping	___	___	___
22. Worry a lot	___	___	___
23. Want to be with parent more than before	___	___	___
24. Feel that you are bad	___	___	___
25. Take unnecessary risks	___	___	___
26. Get hurt frequently	___	___	___
27. Seem to be having less fun	___	___	___
28. Act younger than children your age	___	___	___
29. Do not listen to rules	___	___	___
30. Do not show feelings	___	___	___
31. Do not understand other people's feelings	___	___	___
32. Tease others	___	___	___
33. Blame others for your troubles	___	___	___
34. Take things that do not belong to you	___	___	___
35. Refuse to share	___	___	___

Patient Health Questionnaire-2 (PHQ-2)

Instructions:

Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. **Little interest or pleasure in doing things**

   ☐0 ☐1 ☐2 ☐3

2. **Feeling down, depressed, or hopeless**

   ☐0 ☐1 ☐2 ☐3

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: _ _

Developed by Drs. R.L. Spitzer, J.B. Williams, K. Kroenke and colleagues with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.