South Lake Pediatrics
Infant, Child & Adolescent Care
www.southlakepediatrics.com
952-401-8300

Parent Questionnaire for Patients (Ages 12-18 years)

Name:	**Acct. No:**
Age:	**DOB:**
Phone:	**PC:**
Date:	**Clinician:**

Parent questionnaire – Please take the time to answer the following questions **on both sides** in order for us to better care for your child.

		Please Circle Answer		Counseled/Referred
Nutrition / Healthy Lifestyle	Does your child have any food, medication or environmental allergies?	No	Yes	
	Has your child required surgery, hospitalization, ER or urgent care visits since his/her last physical/checkup? Please circle	No	Yes	
	Has your child ever felt dizzy or passed out during or after exercise?	No	Yes	
	Do you have any concerns about your child's height, weight or development (including language, vision or hearing)? Please circle	No	Yes	
	Has your child seen the dentist in the last year?	Yes	No	
	Have there been any changes in a family member's health since your last visit (i.e. new onset diabetes, high cholesterol, unhealthy weight, etc)?	No	Yes	
	Do you and your family eat dinner together most nights?	Yes	No	
	How many servings a day does your child get of the following? Please circle Fruit 0-1 2-3 4 or more Vegetables 0-1 2-3 4 or more Dairy 0-1 2-3 4 or more Sweetened beverages (juice, soda, sports drink) 0 1 2 or more			
	How many meals does your child eat out per week? Please circle 0 1-2 3 or more			
	How many minutes of exercise/activity does your child get per day? Please circle 0-30 30-60 60 or more			
	How many hours of TV, computer, and video game time does your child spend a day? Please circle 0-1 2-3 4 or more			
	Is there a TV, VCR, DVD, video game or computer in your child's bedroom?	No	Yes	
Social	Do you monitor your child's online activities and TV watching?	Yes	No	
	Has there been a major change in your life recently due to moving, divorce, remarriage, new job, parent, illness or other stressor? Please circle	No	Yes	
	How does your child do in school? Please circle Top 1/4 Middle Bottom 1/4 School and grade:			
	Do you feel comfortable with your child's friends?	Yes	No	
	Does your child discuss problems with you?	Yes	No	
	Do you talk to your child about relationships and/or sexuality?	Yes	No	
	Has your child ever been in trouble with school or the law?	No	Yes	
	Do you and your spouse/partner agree on rules?	Yes	No	
	Does anyone in your child's family have a problem with drugs or alcohol?	No	Yes	
	Does your child or his/her friends use alcohol, drugs, cigarettes, e-cigarettes, chewing tobacco, or hookahs?	No	Yes	
	Does your child make bets or gamble?	No	Yes	
	Has your child ever tried to hurt him or herself or tried to commit suicide?	No	Yes	

– OVER – **PLEASE COMPLETE BOTH SIDES**

		Please Circle Answer		Counseled/Referred
Safety	Do you or your child often feel sad or alone?	No	Yes	
	Do you or your child often feel stressed, anxious, angry, or depressed?	No	Yes	
	Have you or your children ever been hurt, threatened or treated badly?	No	Yes	
	Do you keep handguns, rifles, BB guns, bow and arrows or other weapons in your home? Please circle	No	Yes	
	Do you and your child always wear seatbelts when you are in the car?	Yes	No	
	Do you and your child always wear a helmet when riding a bike, motorcycle or ATV, snowmobiling, skiing, snowboarding or when rollerblading? Please circle	Yes	No	
	Do you have working smoke and carbon monoxide detectors in your home?	Yes	No	
TB Exposure	Has your child lived in or visited another country for more than 1 month in the past 12 months? Which country? How long? _____	No	Yes	
	Has your child been exposed to anyone with TB disease, or to anyone who has had a positive skin test for TB?	No	Yes	
	Does your child spend time with anyone who works, visits, or has been in jail, prison, or a homeless shelter, or who uses illegal drugs, or has HIV?	No	Yes	

☐ **Questions reviewed and safety/anticipatory guidance provided to patient/family.**

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Clinician Initials

– OVER –

PLEASE COMPLETE BOTH SIDES