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

Parent Questionnaire for Patients (Ages 6-11)

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	Has your child required surgery, hospitalization, Urgent Care or ER visits since their last physical/checkup? Please circle	No	Yes	
	Does your child have any food, medication or environmental allergies?	No	Yes	
	Do you have any concerns about your child's height, weight, or physical development (including language, vision or hearing)? Please circle	No	Yes	
	Has your child ever passed out or felt dizzy during play or exercise?	No	Yes	
	Has your child been to the dentist in the last year?	Yes	No	
	Do you have well water and/or a reverse osmosis filter?	No	Yes	
	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	
	Please list any sports, hobbies or after school activities in which your child participates in.			
	Do you and your family eat dinner together most nights?	Yes	No	
	How many servings a day of the following does your child get? Please circle Fruits 0-1 2-3 4 or more Vegetables 0-1 2-3 4 or more Dairy 0-1 2-3 4 or more Sweetened drinks (juice, soda, sports drink) 0-1 2-3 3 or more			
	How many meals does your child eat out per week? Please circle 0-1 2-3 4 or more			
	How many minutes of activity does your child get on an average day? Please circle 0-30 30-60 60 or more			
	How many hours of screen time (computer, TV, video games, etc) does your child have a day? Please circle 0-1 hr 2hrs 3 or more hours			
	Does your child have a TV, VCR, DVD, video game or computer in your child's bedroom?	No	Yes	
Social	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 Name of school and grade?			
	Do you feel your child needs help with behavior or discipline issues?	No	Yes	
	Do you and your spouse/partner agree on rules?	Yes	No	
	Do you have any concerns regarding the use of alcohol or drugs by anyone in your family or by anyone caring for your child?	No	Yes	
	Have you finished the other side of this questionaire?	Yes	No	

– OVER – **PLEASE COMPLETE BOTH SIDES**

		Please Circle Answer		Counseled/Referred
Safety	Have you or your child ever been hurt, threatened or treated badly?	No	Yes	
	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	
	Do you discuss with your child issues regarding stranger avoidance and good/bad touch and bullying?	Yes	No	
	Do you keep handguns, rifles, BB guns, bow and arrows or other weapons in your home? Please circle	No	Yes	
	Do you have working smoke and carbon monoxide detectors in your home?	Yes	No	
	Do you have fire/emergency escape plans in your home?	Yes	No	
	If your child is less than 4ft. 9in. does he/she use a booster seat in the car?	Yes	No	
	Does your child sit in the front seat of the car?	No	Yes	
	Do you and your child always wear a helmet when riding a bike, motorcycle or ATV, snowmobiling, skiing, snowboarding, or when using rollerblades? Please circle	Yes	No	
	Do you as a parent always wear a seatbelt when you are in the car?	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 family.**

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Clinician Initials

– OVER –

PLEASE COMPLETE BOTH SIDES