



Barrow Pediatrics

and Adolescent Medicine

Please Follow These Instructions and Bring the Completed Form to Your Visit:

You can: 1) Use a Computer to complete your answers; or 2) Print out a blank form and use a pen to complete your answers. For those with access to a Computer, Option #1 will be the easiest method.

Option #1: Complete the Form using a Computer:

1. Open the downloaded PDF file and complete the Well-Check form using your Computer.
2. **Save all changes.** *You will lose your work* if you do not save your changes before printing out the completed form.
3. Print out the completed Well-Check form as a one-sided document on front-side of pages.
4. Bring the completed, printed form to our office at your appointment time.
5. Give the completed form to our receptionist.

Option #2: Print Out a Blank Form and use a pen to complete your answers.

1. Open the downloaded PDF file and print out a blank Well-Check form as a one-sided document on front-side of pages.
2. Complete the Well-Check form using a pen.
3. Bring the completed, printed form to our office at your appointment time.
4. Give the completed form to our receptionist.

NOTE: Parents of 11-12 year olds, 13-14 year olds, and 15-17 year olds have a separate Parent Well-Check form to complete for your child. This additional form is included in the downloaded PDF form file.

Thank You for Completing Your Child's Well-Check Form in Advance!

This will help reduce the wait time spent at your child's office visit.

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

11 THROUGH 14 YEAR VISITS FOR PATIENTS

To give you the best possible health care, we would like to know how things are going. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. **Depression screening (beginning at age 12) and Tobacco, Alcohol, or Drug Use assessment are also part of this visit.** Thank you for your time.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

TELL US ABOUT YOURSELF.

What are you most proud of about yourself?

Have there been major changes lately in your family's life? No Yes, describe:

Have any of your relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

GROWING AND DEVELOPING

Check off all the items that you feel are true for you.

- | | |
|---|--|
| <input type="checkbox"/> I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe. | <input type="checkbox"/> I help others. |
| <input type="checkbox"/> I have at least one adult in my life who I know I can go to if I need help. | <input type="checkbox"/> I am able to bounce back when life doesn't go my way. |
| <input type="checkbox"/> I have a friend or a group of friends that I feel comfortable to be around. | <input type="checkbox"/> I feel hopeful and confident. |
| | <input type="checkbox"/> I am becoming more independent and I make more of my own decisions. |

11 THROUGH 14 YEAR VISITS FOR PATIENTS

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	For girls: Do you have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	For girls: Does your period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Do you smoke cigarettes or use e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how well you see?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence (Fighting and Bullying)			
Have you been part of a gang or a group that has gotten or could get into trouble?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you been in a fight in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you know anyone in a gang?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have ways that help you deal with feeling angry?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you feel safe at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you ever been bullied in person, on the Internet, or through social media?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you been in a relationship with a person who threatened you physically or hurt you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been touched in a way that made you feel uncomfortable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has anyone touched your private parts without your agreement or against your wishes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been forced or pressured to do something sexually that you didn't want to do?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Do you spend time talking with your parents every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do your parents praise you when you do something good or learn something new?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you get along with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have an adult you feel connected to?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have rules at home and know what happens when you break the rules?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Do you have activities or things you like to do after school or on the weekends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you help others at home, in school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Are you doing well at school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have things you enjoy doing at school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are you having any problems in school? Are there things you need help figuring out?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you get extra help or support in any subjects at school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Coping With Stress and Decision-making			
Do you worry a lot or feel overly stressed out?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have things you do to feel better when you are stressed?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS

YOUR GROWING AND CHANGING BODY

Healthy Teeth			
Do you brush your teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
If you play contact sports, do you wear a mouth guard?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Body Image			
Do you have any concerns about your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you teased about your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you currently doing anything to try to gain or lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you have healthy food options at home and in school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you eat fruits and vegetables every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you drink juice, soda, sports drinks, or energy drinks?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you ever skip meals?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Physical Activity and Sleep			
Are you physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time every day do you spend watching TV, playing video games, or using computers, tablets or smartphones (not counting schoolwork)?	_____ hours		
Do you get 8 or more hours of sleep each night?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble sleeping?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

EMOTIONAL WELL-BEING

Do you and your parents argue a lot about what your culture expects of you and what your friends are doing?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you talked with your parents about dating and sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have questions or concerns about how your body is changing (puberty)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
For girls: Have you started your period?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
For girls: If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships			
Have you ever been in a romantic relationship?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If yes, have you always felt safe and respected?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> Sometimes
<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs			
Have you ever smoked cigarettes or used e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever drunk alcohol?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been offered any drugs?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever used drugs (including marijuana or street drugs)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Acoustic Trauma			
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS

STAYING SAFE

Seatbelt and Helmet Use			
Do you always wear a lap and shoulder seat belt?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you always wear a life jacket when you do water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Sun Protection			
Do you use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you visit tanning parlors?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Substance Use and Riding in a Vehicle			
Have you ever ridden in a car with someone who has been drinking or using drugs?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have someone you can call for a ride if you feel unsafe riding with someone?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Gun Safety			
Have you ever carried a gun or knife (even for self-protection)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If there is a gun in your home, do you know how to get hold of it?	<input type="radio"/> NA	<input type="radio"/> No	<input type="radio"/> Sometimes <input type="radio"/> Yes

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.



American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

11 THROUGH 14 YEAR VISITS FOR PARENTS

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? No Yes, describe:

Have there been major changes lately in your family's life? No Yes, describe:

Have any of your child's relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

YOUR GROWING AND DEVELOPING CHILD

Check off all the items that you feel are true for your child.

- | | |
|--|---|
| <input type="checkbox"/> My child does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe. | <input type="checkbox"/> My child helps others by himself or by working with a group in school, a faith-based organization, or the community. |
| <input type="checkbox"/> My child has at least one adult in his life who cares about him and knows he can go to if he needs help. | <input type="checkbox"/> My child is able to bounce back when things don't go her way. |
| <input type="checkbox"/> My child has at least one friend or a group of friends who she feels comfortable around. | <input type="checkbox"/> My child feels hopeful and self-confident. |
| | <input type="checkbox"/> My child is becoming more independent and making more decisions on his own as he gets older. |

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your family ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your child is female , does she have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your child is female , does her period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Hearing	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Sexually transmitted infections/ HIV	Adolescents who are sexually active are at risk of sexually transmitted infection, including HIV. Adolescents who use injection drugs are at risk of HIV. Are you concerned that your young adolescent might be at risk?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Tuberculosis	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child tend to squint?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Interpersonal Violence (Fighting and Bullying)			
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Is your child involved in any of the violence?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you think your child is safe in the neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your child ever been injured in a fight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your child been bullied or hurt by others?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your child bullied or been aggressive toward others?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you talked with your child about violence in dating situations and how to be safe?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Living Situation and Food Security			
Do you have concerns about your living situation?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have enough heat, hot water, and electricity?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have appliances that work?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have problems with bugs, rodents, or peeling paint or plaster?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

YOUR FAMILY'S HEALTH AND WELL-BEING (CONTINUED)

Alcohol and Drugs			
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Does your family get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you take time to talk with your child every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you let your child know when he does something good?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Does your child have interests outside of school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child help others at home, in school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Is your child getting to school on time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Is your child having any problems at school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your child complete homework on time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your child missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Coping With Stress and Decision-making			
Does your child worry too much or appear overly anxious?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you discussed ways to deal with stress?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you help your child make decisions and solve problems?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

YOUR GROWING AND CHANGING CHILD

Healthy Teeth			
Does your child see the dentist regularly?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble getting dental care?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Body Image			
Do you have any concerns about your child's nutrition, weight, or physical activity?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your child talk about getting fat or dieting to lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you think your child eats healthy foods?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have any difficulty getting healthy food for your family?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have any concerns about your child's eating habits or nutrition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together as a family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Physical Activity and Sleep			
Is your child physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are there opportunities to safely play outside in your neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you and your child participate in physical activities together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time does your child spend on recreational screen time each day?	_____ hours		
Does your child have a TV, computer, tablet, or smartphone in his bedroom?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have rules about screen time for your child?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

YOUR CHILD'S EMOTIONAL WELL-BEING

Mood and Mental Health			
Is your child frequently irritable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you noticed any changes in your child's weight or sleep habits?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you and your child often have conflicts about what your culture expects for her behavior and how her friends behave?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have any concerns about your child's emotional health, such as being frequently sad or depressed?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Sexuality			
Have you and your child talked about how his body will change during puberty?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have house rules about curfews, dating, and friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

HEALTHY BEHAVIOR CHOICES

Sexual Activity			
Have you and your child talked about sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked about ways to deal with any pressures to have sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Substance Use			
Have you talked with your child about alcohol and drug use?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know your child's friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know where your child is and what she does after school and on the weekends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have consequences for your child if you discover he is using tobacco, alcohol, or drugs?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
To your knowledge, is your child currently using alcohol or drugs, or has she used them in the past?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Acoustic Trauma			
Does your child often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

SAFETY

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt and bicycle helmet?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you insist your child wears a lap and shoulder seat belt when in a car?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you insist that your child use a life jacket when he does water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Sun Protection			
Does your child use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Gun Safety			
Is there a gun in your home or the homes where your child visits?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.

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The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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