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.

CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

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.

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

PATIENT NAME: _____ DATE: _____

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	O Yes	O No	O Unsure
	For girls: Do you have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	For girls: Does your period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Do you smoke cigarettes or use e-cigarettes?	O No	O Yes	O Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).**	O No	O Yes	O Unsure
	Are you having unprotected sex?	O No	O Yes	O Unsure
	Are you having sex with multiple partners or anonymous partners?	O No	O Yes	O Unsure
	Are you or any of your past or current sexual partners bisexual?	O No	O Yes	O Unsure
	Have you ever been treated for a sexually transmitted infection?	O No	O Yes	O Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	O No	O Yes	O Unsure
	Do you trade sex for money or drugs or have sex partners who do?	O No	O Yes	O Unsure
	For boys: Have you ever had sex with other males?	O No	O Yes	O Unsure
HIV	Do you now use or have you ever used injection drugs?	O No	O Yes	O Unsure
Tuberculosis	Are you infected with HIV?	O No	O Yes	O Unsure
	Were you or was 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)?	O No	O Yes	O Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about how well you see?	O No	O Yes	O 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?	O No	O Sometimes	O Yes
Have you been in a fight in the past 6 months?	O No	O Sometimes	O Yes
Do you know anyone in a gang?	O No	O Sometimes	O Yes
Do you have ways that help you deal with feeling angry?	O Yes	O Sometimes	O No
Do you feel safe at home?	O Yes	O Sometimes	O No
Have you ever been bullied in person, on the Internet, or through social media?	O No	O Sometimes	O Yes
Have you been in a relationship with a person who threatened you physically or hurt you?	O No	O Sometimes	O Yes
Have you ever been touched in a way that made you feel uncomfortable?	O No	O Sometimes	O Yes
Has anyone touched your private parts without your agreement or against your wishes?	O No	O Sometimes	O Yes
Have you ever been forced or pressured to do something sexually that you didn't want to do?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Do you spend time talking with your parents every day?	O Yes	O Sometimes	O No
Do your parents praise you when you do something good or learn something new?	O Yes	O Sometimes	O No

PATIENT NAME: _____ DATE: _____

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

HOW YOU ARE DOING (*CONTINUED*)

Connectedness With Family and Peers (*continued*)			
Do you get along with your family?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Do you have an adult you feel connected to?	O Yes	O Sometimes	O No
Do you have rules at home and know what happens when you break the rules?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have activities or things you like to do after school or on the weekends?	O Yes	O Sometimes	O No
Do you help others at home, in school, or in your community?	O Yes	O Sometimes	O No
School Performance			
Are you doing well at school?	O Yes	O Sometimes	O No
Do you have things you enjoy doing at school?	O Yes	O Sometimes	O No
Are you having any problems in school? Are there things you need help figuring out?	O No	O Sometimes	O Yes
Do you get extra help or support in any subjects at school?	O No	O Sometimes	O Yes
Coping With Stress and Decision-making			
Do you worry a lot or feel overly stressed out?	O No	O Sometimes	O Yes
Do you have things you do to feel better when you are stressed?	O Yes	O Sometimes	O No

YOUR GROWING AND CHANGING BODY

Healthy Teeth			
Do you brush your teeth twice a day?	O Yes	O Sometimes	O No
Do you see the dentist twice a year?	O Yes	O Sometimes	O No
If you play contact sports, do you wear a mouth guard?	O Yes	O Sometimes	O No
Body Image			
Do you have any concerns about your weight?	O No	O Sometimes	O Yes
Are you teased about your weight?	O No	O Sometimes	O Yes
Are you currently doing anything to try to gain or lose weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you have healthy food options at home and in school?	O Yes	O Sometimes	O No
Do you eat fruits and vegetables every day?	O Yes	O Sometimes	O No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	O Yes	O Sometimes	O No
Do you drink juice, soda, sports drinks, or energy drinks?	O No	O Sometimes	O Yes
Do you ever skip meals?	O No	O Sometimes	O Yes
Do you eat meals together with your family?	O Yes	O Sometimes	O 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.	O Yes	O Sometimes	O 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?	O Yes	O Sometimes	O No
Do you have trouble sleeping?	O No	O Sometimes	O 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?	O No	O Sometimes	O Yes
Have you talked with your parents about dating and sex?	O Yes	O Sometimes	O No
Do you have questions or concerns about how your body is changing (puberty)?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS (SENSITIVE QUESTIONS INCLUDED)

EMOTIONAL WELL-BEING (*CONTINUED*)

For girls: Have you started your period?	O No	O Sometimes	O Yes
For girls: If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)?	O No	O Sometimes	O Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity			
Have you ever been in a romantic relationship?	O No	O Sometimes	O Yes
If yes, have you always felt safe and respected?	O Yes	O Sometimes	O No
Have you ever had sex, including oral, vaginal, or anal sex? *If no, skip to the next section.*	O No	O Sometimes	O Yes
Do you and your partner use condoms every time?	O Yes	O Sometimes	O No
Do you and your partner always use another form of birth control along with a condom?	O Yes	O Sometimes	O No
Are you aware of emergency contraception?	O Yes	O Sometimes	O No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs			
Have you ever smoked cigarettes or used e-cigarettes?	O No	O Sometimes	O Yes
Have you ever drunk alcohol?	O No	O Sometimes	O Yes
Have you ever been offered any drugs?	O No	O Sometimes	O Yes
Have you ever used drugs (including marijuana or street drugs)?	O No	O Sometimes	O Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?	O No	O Sometimes	O Yes
Acoustic Trauma			
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	O Yes	O Sometimes	O No
Do you often listen to loud music?	O No	O Sometimes	O Yes

STAYING SAFE

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

CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

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.

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

PATIENT NAME: _____ DATE: _____

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?	O Yes	O No	O Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	O No	O Yes	O Unsure
	Does your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	If your child is female, does she have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	If your child is female, does her period last more than 5 days?	O No	O Yes	O 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)?	O No	O Yes	O Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O 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?	O No	O Yes	O Unsure
Tuberculosis	Is your child infected with HIV?	O No	O Yes	O 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)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Does your child have trouble with near or far vision?	O No	O Yes	O Unsure
	Has your child ever failed a school vision screening test?	O No	O Yes	O Unsure
	Does your child tend to squint?	O No	O Yes	O 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?	O No	O Sometimes	O Yes
Is your child involved in any of the violence?	O No	O Sometimes	O Yes
Do you think your child is safe in the neighborhood?	O Yes	O Sometimes	O No
Has your child ever been injured in a fight?	O No	O Sometimes	O Yes
Has your child been bullied or hurt by others?	O No	O Sometimes	O Yes
Has your child bullied or been aggressive toward others?	O No	O Sometimes	O Yes
Have you talked with your child about violence in dating situations and how to be safe?	O Yes	O Sometimes	O No
Living Situation and Food Security			
Do you have concerns about your living situation?	O No	O Sometimes	O Yes
Do you have enough heat, hot water, and electricity?	O Yes	O Sometimes	O No
Do you have appliances that work?	O Yes	O Sometimes	O No
Do you have problems with bugs, rodents, or peeling paint or plaster?	O No	O Sometimes	O Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?	O No	O Sometimes	O Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

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

YOUR GROWING AND CHANGING CHILD

Healthy Teeth			
Does your child see the dentist regularly?	O Yes	O Sometimes	O No
Do you have trouble getting dental care?	O No	O Sometimes	O Yes
Body Image			
Do you have any concerns about your child's nutrition, weight, or physical activity?	O No	O Sometimes	O Yes
Does your child talk about getting fat or dieting to lose weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you think your child eats healthy foods?	O Yes	O Sometimes	O No
Do you have any difficulty getting healthy food for your family?	O No	O Sometimes	O Yes
Do you have any concerns about your child's eating habits or nutrition?	O No	O Sometimes	O Yes
Do you eat meals together as a family?	O Yes	O Sometimes	O 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.	O Yes	O Sometimes	O No
Are there opportunities to safely play outside in your neighborhood?	O Yes	O Sometimes	O No
Do you and your child participate in physical activities together?	O Yes	O Sometimes	O 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?	O No	O Sometimes	O Yes
Do you have rules about screen time for your child?	O Yes	O Sometimes	O No
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O Sometimes	O No
Does your child have a regular bedtime?	O Yes	O Sometimes	O No

PATIENT NAME: _____ DATE: _____

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

YOUR CHILD'S EMOTIONAL WELL-BEING

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

HEALTHY BEHAVIOR CHOICES

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

SAFETY

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

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®