8-9 Year Old Questionnaire

Patient's Name:_____

Personal/Social History

Are you concerned about your child's...

1. Wheezing/asthma ..... ☐ Yes ☐ No
2. Skin color or rashes (circle one)? ..... ☐ Yes ☐ No
3. Overall development? ..... ☐ Yes ☐ No
4. Communication skills? ..... ☐ Yes ☐ No
5. Bed wetting, soiling, or urinary control? ..... ☐ Yes ☐ No
6. Weight loss or gain? ..... ☐ Yes ☐ No
7. Recurrent ear infections? ..... ☐ Yes ☐ No
8. Nose bleeds or bruising? ..... ☐ Yes ☐ No
9. Weakness with walking up stairs, running, or climbing? ..... ☐ Yes ☐ No
10. Behavior at school, home, or daycare? ..... ☐ Yes ☐ No
11. Food allergies? ..... ☐ Yes ☐ No
12. Seasonal allergies? ..... ☐ Yes ☐ No
13. Chest pain? ..... ☐ Yes ☐ No
14. Chronic abdominal pain? ..... ☐ Yes ☐ No
15. Joint pain, joint swelling or limp? ..... ☐ Yes ☐ No
16. Overall progress/happiness/performance at school? ..... ☐ Yes ☐ No
17. Poor diet and/or picky eating? ..... ☐ Yes ☐ No

Answer the following:

18. Is your child exposed to tobacco smoke? ..... ☐ Yes ☐ No
19. Is your water source from a well? ..... ☐ Yes ☐ No
20. Is your child on the computer or playing video games or watching TV more than 2 hours per day? ..... ☐ Yes ☐ No

Does your child...

21. Have any speech delays? ..... ☐ Yes ☐ No
22. Have problems sitting in their seat and paying attention at school? ..... ☐ Yes ☐ No
23. Have problems with their academic performance in school? ..... ☐ Yes ☐ No
24. Seem unhappy or have problems with their self esteem? ..... ☐ Yes ☐ No
25. Have problems following the rules at school? ..... ☐ Yes ☐ No
26. Have problems with his temper or anger? ..... ☐ Yes ☐ No

Answer the following:

27. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
28. Do you know CPR? ..... ☐ Yes ☐ No
29. Are you giving your child a multivitamin with iron? ..... ☐ Yes ☐ No
30. Is your child eating all food groups: fruits, meats, and vegetables? ..... ☐ Yes ☐ No
31. Is your child brushing their teeth? ..... ☐ Yes ☐ No
32. Is your child seeing the dentist every 6 months? ..... ☐ Yes ☐ No
33. Does your child consistently use a seat belt and ride only in the back seat? ..... ☐ Yes ☐ No
34. Does your child always use a bike helmet when riding a bike? ..... ☐ Yes ☐ No

8-9 Year Old Questionnaire

Does your child...

35. Interact positively with teachers and friends and babysitters and siblings? ..... ☐ Yes ☐ No
36. Ride a bike without training wheels? ..... ☐ Yes ☐ No
37. Run well and keep up with their friends? ..... ☐ Yes ☐ No
38. Have adult supervision before and after school? ..... ☐ Yes ☐ No
39. Have regular chores? ..... ☐ Yes ☐ No
40. Participate in a sport or other organized activity? ..... ☐ Yes ☐ No
41. How many ounces of milk does your child drink in one day? _____ What kind? _____
42. How many ounces of juice does your child drink in one day? _____

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? ..... ☐ Yes ☐ No
3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ..... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ..... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? ..... ☐ Yes ☐ No
6. Do you plan to travel to a high risk country (one NOT listed above) within the next year? ..... ☐ Yes ☐ No

Diabetes/Cholesterol Screening Questions:

1. Does either parent have high cholesterol? ..... ☐ Yes ☐ No
2. Is there a family history of stroke or heart attack in women under 65 or male relatives under 55? ..... ☐ Yes ☐ No
3. Are the questions asked above unknown? ..... ☐ Yes ☐ No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ..... ☐ Yes ☐ No

_____

_____

_____

_____

_____

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still	0	1	2
❊	Feel sad, unhappy	0	1	2
◆	Daydream too much	0	1	2
❑	Refuse to share	0	1	2
❑	Do not understand other people's feelings	0	1	2
❊	Feel hopeless	0	1	2
◆	Have trouble concentrating	0	1	2
❑	Fight with other children	0	1	2
❊	Down on yourself	0	1	2
❑	Blame others for your troubles	0	1	2
❊	Seem to be having less fun	0	1	2
❑	Do not listen to rules	0	1	2
◆	Act as if driven by a motor	0	1	2
❑	Tease others	0	1	2
❊	Worry a lot	0	1	2
❑	Take things that do not belong to you	0	1	2
◆	Distract easily	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____