PARENT QUESTIONNAIRE TEEN WELL CHECK
CUESTIONARIO PARA LOS PADRES EXAMEN DEL ADOLECENTE SALUDABLE

Dear Parent,
Because we want to give your teenager the best health care, we are asking your teen to complete a private questionnaire. We would like to know if your teen has any questions about health or development, or if your teen has behaviors that could hurt him or herself or others. We would like parents to complete this separate questionnaire. During this visit we will try to answer all your questions as well as those of your teen. Thank you for your help.

Estimados padres de familia:
Ya que deseamos brindar a sus hijos adolescentes la mejor atencion medica, estamos solicitando a sus hijos adolescentes que llenen un cuestionario confidencial. Deseamos saber si su hijo adolescente tiene alguna presunta sobre la salud o el desarrollo, o si su hijo adolescente tiene comportamientos que pudieran ser perjudiciales para si mismo o para los demas. Deseamos que los padres llenen este cuestionario aparte. Durante esta consulta trataremos de contestar sus preguntas y tambien las de su hijo adolescente. Muchas gracias por su ayuda.

State law permits adolescents to receive confidential care for certain types of medical conditions **Las leyes estatales permiten que los adolescentes reciban cuidado confidencial para cierto tipe de afecciones medicas.**

1. **Do you have concerns about your teen's health or lifestyle?** **If yes, please describe**:_____ ¿Tiene preocupaciones sobre la salud o estilo de vida de sus hijo adolescente? En caso afirmativo, por favor describalas:	☐ Yes/Si ☐ No
2. **Have there been any major changes or stresses in your family since your last visit? If yes, please describe:** _____ **¿**Ha habido cambios mayores o fuentes de estres en su familia desde su ultima consulta? En caso afirmativo, por favor, describalas:	☐ Yes/Si ☐ No
3. **Have you noticed any changes in your teen's behavior: unusual anger or irritability, withdrawal, secrecy, sadness, depression, or problems at school? If yes, please describe**_____ ¿Ha notado algun cambio en el comportamiento de su hijo (a) adolescente: ira o irritabilidad inusual, retraimiento, reserva, tristeza, depresion, problemas en la escuela? En caso afirmativo, por favor, describalos:	☐ Yes/Si ☐ No
4. **Does your child see a dentist at least once a year?** ¿Va su hijo(a) al dentista por lo menos una vez al año?	☐ Yes/Si ☐ No
5. **Has your child had any serious medical problems since his/her last routine check up?** ¿Ha tenido su hijo(a) algun problema medico serio desde su ultimo examen de rutina?	☐ Yes/Si ☐ No
6. **Is your child taking any medications? If yes, please list them:** ¿Esta tomando su hijo algun medicamento? En caso afirmativo, por favor enumerelos: _____	☐ Yes/Si ☐ No
7. **Is your child allergic to any medications? If yes, please list them:** ¿En su hijo(a) alergico a algun medicamento? En caso afirmativo, por favor enumerelos: _____	☐ Yes/Si ☐ No
8. **Does your child have any missing organs? (such as eye, kidney, testicle)** ¿Le falta a su niño algun organo? (tal como un ojo, riñon, testiculo)	☐ Yes/Si ☐ No
9. **Have your child's parents or grandparents (blood relatives) had a heart attack or stroke before age 55 in men and 65 in women?** ¿Han tenido los padres o los abuelos del niño (parientes de sangre) un ataque cardiaco o un derrame cerebral antes de los 55 años en los hombres o los 65 años en las mujeres?	☐ Yes/Si ☐ No
10. **Has your child ever fainted during exercise?** ¿Se ha desmayado alguna vez su hijo(a) haciendo ejercicio?	☐ Yes/Si ☐ No
11. **Has your child ever had a concussion (serious head injury) or been unconsious?** ¿Ha tenido alguna vez su hijo(a) una concusion (una herida seria en la cabeza) o ha estado inconciente?	☐ Yes/Si ☐ No
12. **Has anyone who lives in your house or a babysitter ever had a positive TB (Tuberculosis) skin test or active TB?** ¿Hay alguna persona que vive en su casa o una niñera que haya tenido una prueba de la piel de TB positiva (Tuberculosis) o una tuberculosis activa?	☐ Yes/Si ☐ No
13. **Were you (or any household member) born outside of the United States or have you recently traveled to a developing country (Central or South America, Asia or Africa)?** ¿Usted (o cualquier otro miembro de la familia) ha nacido fuera de los Estados Unidos o viajado recientemente a un pais en desarrollo (America Central o de Sur, Asia o Africa)?	☐ Yes/Si ☐ No
14. **Has your child lived outside the U.S. for more than one month?** ¿Ha vivido su hijo(a) fuera de los Estados Unidos por mas de un mes?	☐ Yes/Si ☐ No

If you have any other concerns, please write them here/Si tiene algun tipo de inquietudes, escribalas aqui:
_____
_____

Please enter your phone number in case we need to call: Por favor provea su numero de telefono en caso de que le necesitemos llamar: _____ **Phone Number**/Numero de Telefono

Good times to call you/ Mejor hora para llamarle: _____

E-mail Address/ Direccion de Correo Electronico: _____

Signature/Firma: _____ **Date/**Fecha: _____

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.				
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature:		Print Name:			Date:
SHA ANNUAL REVIEW					
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:

Tuberculosis Risk Assessment Screening Questionnaire

Today's Date: _____

Name: _____ **Date of Birth:** _____

***If your child has the appointment today, please fill out the form as it pertains to the child.

Circle any symptoms you are experiencing today:

Cough Fever Loss of Appetite Coughing Up Blood Fatigue Weight Loss Night Sweats

1. Have you ever had a **positive** TB Skin Test or **positive** TB Blood Test (Quantiferon Level)? **(If YES, also answer A-D below). (If NO, skip to Question #2).** _____ **Answer only if history of positive TB Test:** A. Date of positive test? _____ B. Date of last chest x-ray? _____ Normal: **Yes** **No** C. Was a preventive treatment for tuberculosis taken (such as INH)? **Yes** **No** D. Preventative treatment dates? _____	YES	NO
2. Have you had any of the following vaccines: Measles/Mumps/Rubella, Varicella, Zostavax or Nasal flu vaccine in the past 4 weeks?	YES	NO
3. Do you have close contact with someone who has, active Tuberculosis?	YES	NO
4. In the last 5 years have you lived or worked in prison, hospital, nursing home, homeless shelter, foster care or group home?	YES	NO
5. Were you born in Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico?	YES	NO
6. In the last 2 years have you traveled to Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico?	YES	NO
7. Are you currently homeless, a migrant worker, or use street drugs?	YES	NO

I have received information about the TB skin test and have had the opportunity to ask any questions which were answered to my satisfaction. I agree to return in **48-72 hours** to have my TB test read. I understand the risks and benefits of the TB skin test and request the test be administered to me. I understand that if I am symptomatic for TB, or the TB skin test is positive, I will need to follow up with my Primary Care Physician and further treatment may be necessary.

Form Completed By (Signature): _____ **Date:** _____

Print Name: _____

Relationship to Patient: (Self), (Parent), (Guardian), Other): _____

PATIENT IDENTIFICATION LABEL

PHQ2 + 1
Pre Screen Questionnaire for Depression

1. Over the past two weeks, have you often been bothered by feeling little interest or pleasure in doing things?

YES ____ NO____

2. Over the past two weeks, have you been bothered by feeling down, depressed, or hopeless?

YES ____ NO____

+ 1. Have you been referred to a Mental Health/Behavioral Health Provider in the last 30 days?

YES ____ NO____

FOR STAFF USE:
If any of above questions is answered YES, ask the following question:

Are you currently being seen by a Mental Health/Behavioral Health Provider

YES ____ NO____

If above question is answered NO, administer the PHQ-9 Depression Screen.

If above question is answered YES, ask only Question #9 of PHQ9:

"In the last two weeks how often have you had thoughts that you would be better off dead, or hurting yourself?"

Not at all __ Several days ___ More than half of the days____ Nearly every day

If above Question (#9 of PHQ9) is answered 1-3, a Risk Assessment will be completed by RN, LVN or a Provider during visit.

What Follow up action was taken?

__Patient Refused PHQ-2

__Patient given the PHQ-9

_ Patient seen by PCP last 2 weeks

__Patient referred to BH Provider

__Patient Refused PHQ-9

__Patient declined referral to BH

_ Patient in treatment Borrego Health/Elsewhere

__Referral pending with Behavioral Health

Other: _____

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf ▪ Item #P4060 (9/17)

What Do You Eat?
(Ages 8-19)

Circle the names of foods you eat often:

Iron/Protein

Chicken/Turkey	Ham/Pork	Seafood	Eggs	Tofu
Hamburger	Fried Chicken	Tacos	Peanut	Pizza
Whole Grain Bread	Peanut Butter	Cereal	Rice	Hot dog
Meat/Bean Burrito	Noodle Soup	Tortilla	Beef	Pasta
Sweet Bread	Beans/Lentils	White Bread	Potato	Dark
Green Leafy Vegetables	Spaghetti with Meatballs			

Fruits and Vegetables

Cucumber	Broccoli	Banana	100% Juice	Pear	Pea
Pineapple	Bell pepper	Orange	Carrots	Apple	Mango
Cantaloupe	Chili Pepper	Tomato	Grapes	Potato	Corn
Green Salad	Cabbage	Green Beans	Peach	Melon	Strawberry
Dark Green Leafy Vegetables		Sweet Potato			

Snack

Chocolate	French Fries	Fruit Pie	Donut	Candies
Vegetables	Cheese Puffs	Chips	Cookies	Bagels
Mexican Bread	Popcorn	Pretzels	Crackers	Fruits

Drinks

Sports Drinks	100% Fruit Juice	Wine	Soda
Alcoholic Drink	Flavored Drinks	Coffee	Beer
Sweetened Tea	Wine Cooler	Herbal Tea	Tea
Fruit Flavored Soda	Coffee Drink	Energy Drinks	Water

Calcium

Almond butter	Nonfat Milk	Whole Milk	2 % Milk	Prunes
1 % Lowfat Milk	Tempeh	Tahini	Yogurt	Beans
Lactose Free Milk	Ice Cream	Dried Figs	Cheese	Tofu
Cottage Cheese	Milkshake	Soy Beans	Almonds	Corn
Green Leafy Vegetables		Orange	Tortilla	
Calcium Fortified 100% Juice		Calcium Fortified Soy/Plant Milk		

Name: _____ **Age:** _____ **Date of Birth:** _____

Wt: _____lbs **Ht:** _____in **BMI:** _____ **BMI %ile:** _____ **Date:** _____

Office use only:

Circle to indicate the topics discussed:

Healthy eating
Regular meals/snacks
Importance of breakfast
inadequate food supply
Low fat dairy foods
High sugar foods
Other: _____

Iron/Protein

2-3 servings daily
High iron foods
Plant protein sources such as
beans, peas, lentils, nuts, etc.
Limit high fat foods

Fruits and Vegetables

2-4 fruits daily or more
3-5 vegetables daily or more
Vitamin C sources
Vitamin A sources

Calcium

3-4 servings dairy foods/day
Nonfat or 1 % milk Lowfat
dairy choices Low lactose
alternative Calcium
fortified foods
Other food sources of calcium

Snacks

High-sugar snacks
High-fat snacks
Fruit/vegetable snacks
Fast foods

Drinks

< 8-12 oz/day 100% juice
6-8 glasses of water (8 ounces each)/day
Sweetened drinks
Alcohol/caffeine

Referred for identified nutrition problem? **Yes** **No**

If yes, where: _____

Provider initials: _____

DHCS 4035 B (05/16) Adapted from the CHDP Programs of Orange County and San Bernardino Counties

Youth Nutrition and Activity Assessment

(Ages 8 - 19)

Provide additional information about your food, activity and habits:

Eating Habits

Do you eat or drink the following meals? Circle one answer per meal.

Breakfast	**Always**	**Usually**	**Occasionally**	**Never**
Morning snack	**Always**	**Usually**	**Occasionally**	**Never**
Lunch	**Always**	**Usually**	**Occasionally**	**Never**
Afternoon snack	**Always**	**Usually**	**Occasionally**	**Never**
Dinner	**Always**	**Usually**	**Occasionally**	**Never**
Evening Snack	**Always**	**Usually**	**Occasionally**	**Never**

Exercise/Physical Activity

How many hours a day do you?

Watch TV _____hours/day
Use a smart phone _____hours/day
Play video/computer games _____hours/day
Use the internet _____hours/day

Do you participate in physical education classes at school? **Yes** **No**

Circle all that you participate in:

Walking	Running	Bicycling	Swimming
Dance	Yoga	Martial Arts	Rollerblading
Basketball	Softball	Soccer	Volleyball

Other activities or team sports: _____

How often are you physically active?

_____times/week _____minutes/day

Weight/Body Image

Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned

Do you eat less to control your weight? **Yes** **No**

Explain: _____

Have you ever made yourself vomit? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Do you ever "binge" eat? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Circle any of the following that you use:

Diet pills	Laxatives		
Multivitamins	Calcium	Iron	Vitamin D
Protein powder	Nutrition supplements		Steroids

What, if any, other products do you use?

Explain: _____

Office use only

Complete assessment below using all information provided:

Eating Habits

Overall diet adequate	**Yes**	**No**
3 meals and snacks	**Yes**	**No**
High iron foods	**Yes**	**No**
Calcium foods	**Yes**	**No**
5 or more fruits/vegetables	**Yes**	**No**
Adequate fluids	**Yes**	**No**

Exercise/Physical Activity

Limits use of TV, phone, internet, video or computer games to $\leq$ 1-2 hours/day **Yes** **No**

Goal set: _____

Engages in physical activity (60 minutes/day or more) **Yes** **No**

Goal set: _____

Referral made **Yes** **No**

Referred to: _____

Weight/Body Image

BMI %ile _____ Date _____

- ☐ ***BMI between 5th and 85th %iles***
- ☐ ***BMI ≤ 5th %ile***
- ☐ ***BMI between 85th and 95th %iles***
- ☐ ***BMI ≥ 95th %ile***

Signs of eating disorder **Yes** **No**

Counseling given **Yes** **No**

Topics: _____ Goal set: _____

Referral made **Yes** **No**

Referred to: _____