OBERLIN ROAD PEDIATRICS

# Parent Questionnaire for Adolescent Health Care Visit (13-17 Y.O.)

Your Child's Name: _____

Please take a moment to answer the following questions about your child and your family. Your answers are confidential. If you choose not to answer any question, just leave blank.

**Do you have any concerns about the following:**

| | | |
|---|---|---|
| Nutrition, weight, or level of physical activity? | No | Yes |
| About how your family gets along? | No | Yes |
| Puberty, sexuality or gender? | No | Yes |
| Ability to learn or performance at school? | No | Yes |
| Mood or behavior? | No | Yes |
| Friends may be using alcohol, tobacco, or other drugs? | No | Yes |
| Child's friends? | No | Yes |

**Risk Assessment for Tuberculosis Exposure/Infection:**

| | | |
|---|---|---|
| Has a family member or contact had tuberculosis disease? | No | Yes |
| Since your child's last well check has a family member or contact had a positive tuberculosis test? | No | Yes |
| Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)? | No | Yes |
| Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)? | No | Yes |

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? If yes, please describe: No Yes

_____

_____

_____

Any immediate family history of mental health issues? No Yes

If yes, please explain: _____

_____

_____

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# Well Child Check: 13-17 YEAR Visit

## SOCIAL DETERMINANTS OF HEALTH

There are programs to help people with needs that can affect their health, but they aren't reaching everyone who may need them. Are there things you need help with?

**Food**

| | | | |
|---|---|---|---|
| Within the past 12 months, did you worry that your food would run out before you got money to buy more? | No | Yes | |
| Within the past 12 months, did the food you bought just not last and you didn't have money to get more? | No | Yes | |

**Interpersonal Safety**

| | | | |
|---|---|---|---|
| Do you feel physically or emotionally unsafe where you currently live? | No | Yes | |
| Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone? | No | Yes | |
| Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? | No | Yes | |