

Patient Name: _____ Date of Birth: ____/____/____

Please tell me any concerns, questions, problems you have about the way your child is behaving, developing/growth and/or learning:

DEVELOPMENTAL QUESTIONS AND OBSERVATIONS

- YES NO Gets along with family
- YES NO Does chores when asked
- YES NO Is vigorously active for 1 hour a day
- YES NO Spends less than 2 hours per day watching TV, playing video games or using the computer (other than for schoolwork)
- YES NO Eats healthy meals and snacks
- YES NO Eats at least 5 servings of fruits and vegetables a day
- YES NO Eats breakfast regularly
- YES NO Has friends
- YES NO Is doing well in school
- YES NO Participates in an after-school activity
- YES NO Knows how to swim and only swims when an adult is watching
- YES NO Lives in a smoke free home and rides in smoke free automobiles
- YES NO Feels good about him/herself
- YES NO Getting chances to make own decisions
- YES NO Does an activity really well. Please describe: _____

Describe his/her diet by checking all that apply: Rich in Meat Egg Iron fortified Cereal Breads

TUBERCULOSIS

Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)? YES NO

Has your child traveled (had contact with resident populations) for longer than one (1) week to a country at high risk for tuberculosis? YES NO

Has a family member or contact had tuberculosis or a positive tuberculin skins test? YES NO

Is your child infected with HIV? YES NO

DYSLIPIDEMIA

Does your child have parents or grandparents who have had a stroke or heart problem before age 55? YES NO

Does your child have a parent with elevated blood cholesterol (240mg/dL or higher) or who is taking cholesterol medication? YES NO

Additional comments:

Signature: _____ Date: _____ Relationship to Patient: _____

ANEMIA RISK QUESTIONNAIRE

Patient Name: _____

Date of Birth: ____ / ____ / ____

1. Has your child ever been diagnosed with iron deficiency anemia?

Yes No

2. Do you ever have trouble getting food on the table?

Yes No

3. If your child is under the age of 6 months, was your child born premature?

Yes No

4. If your child is under the age of 6 months, did your child have a low birth weight?

Yes No

5. Is your child on a strict vegetarian diet?

Yes No

6. Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

Yes No

7. If your child is under the age of 6 months, is your child drinking anything besides breastmilk or iron-fortified formula?

Yes No

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: ____/____/____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Check boxes to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL:** _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult