BIRTH & BEYOND PEDIATRICS P.C.

# DEVELOPMENTAL SCREENING
## 11&12 YEARS

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: _____
- ☐ YES ☐ NO Little interest or pleasure in doing things
- ☐ YES ☐ NO Feeling down, depressed or hopeless
- ☐ YES ☐ NO Thinking that you would be better off dead or that you want to hurt yourself in some way

Do you smoke cigarettes? ☐ YES ☐ NO

Have you ever had an alcoholic drink? ☐ YES ☐ NO

Have you ever used marijuana or any other drug to get high? ☐ YES ☐ NO

Have you ever had sex? ☐ YES ☐ NO

Are you vegetarian? ☐ YES ☐ NO

Have you ever been diagnosed with iron deficiency anemia? ☐ YES ☐ NO

Does your diet include iron-rich foods such as: ☐ Meats ☐ Eggs ☐ Iron-fortified ☐ Cereals ☐ Beans
*(Please check which ones you eat)*

## 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

CONTINUED ON BACK ▼

## 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: _____

*This screening form was adapted in part by the Ohio Medicaid managed care plans; Ohio Department of Jobs and Family Services, American Academy of Pediatrics, Bright Futures 2010.*

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# 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

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# 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 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **2.** Feeling down, depressed, or hopeless | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **4.** Feeling tired or having little energy | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **5.** Poor appetite or overeating | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **6.** Feeling bad about yourself-or that you are a failure or have let yourself or your family down | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **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 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |

*(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