BAYSHORE PEDIATRIC//PARENTS OF ADOLESCENTS QUESTIONNAIRE

PATIENT NAME:_____ **DATE**_____

Your child is here for a well examination. As your child gets older it is important for your child to begin taking some responsibility in his or her health care. In order to facilitate this natural progression we will meet with your child privately for part of the visit today. This allows your teen to express any concerns or questions he or she may have and allows us to ask questions that may be of a more sensitive nature. Please understand that this part of the examination is kept confidential unless we find that your teen is in danger to him/herself or to others, or we have identified an issue that your teen wishes us to discuss with you. Please encourage your teen to use this time to discuss any issues of concern.

Your teen has been given a questionnaire as well. This questionnaire will be kept confidential. Please also be advised that parent and teen questionnaires are not copied and released with medical records and may be shredded after this visit if you or your teen desires.

Do you have any concerns or questions you would like to discuss with the doctor today? YES_____NO____

(If yes)_____

Do you have any concerns you would like the doctor to discuss with your teenager? YES____NO_____

(if yes)_____

Does anyone in the family have heart disease, diabetes, substance abuse, thyroid problems, mental health issues, cancer, gastrointestinal problems, kidney problems, neurological problems? (circle answers) YES____NO_____

Tell us some of your teens' strength or things you like about him/her: _____

_____

Do you feel your teen is developing a good self image? _____ NO____ YES____
Do you think your child usually uses good judgement? _____ NO____ YES____
Does your teen seem down or withdrawn much of the time ?_____ YES____NO_____
How many school absences has your teen had in the past school year? (approximate _____
Is your teen performing well in school ?_____ NO____ YES____
To your knowledge, has your teen tried cigarettes, alcohol, drugs? (circle answers) _____YES____NO_____
If yes: does your teens use of these substances worry you ?_____YES____NO_____
To your knowledge, has your teen been sexually active?_____ YES____NO_____
If yes: have you discussed contraception and STD prevention with your teen ?_____YES____NO_____
Do you get along with your teen most of the time?_____ NO____ YES____
Has your teen been in trouble with the law?_____ YES____NO_____

Is your family under any serious stress like illness, separation, divorce, death, economic hardship, alcohol or drug abuse? _____YES____NO_____
Please describe:_____

Do you have any firearms in the home?_____YES____NO_____

Does your teen express any physical complaints to you frequently?_____YES____NO_____

Anything else you would like us to know?_____

_____

_____

THANK YOU