

Patient ID _____

Patients Name _____

PCP _____

DOB _____

Today's Date _____

11 – 13 Year Old Parent Observations

Are there any concerns you would like to discuss today? _____

Activities/interests:

How active is your child? very active fairly active occasionally active little/none

List any extracurricular activities (i.e. a sport, dance): _____

List any interests (i.e. instrument, art, playing outside): _____

How much screen time (TV/tablet/phone/video games) does your child have per day? _____

Are there parental controls/monitoring in place for electronics/social media? Yes No

Diet/Physical Development/Sleep:

Does your child eat well (i.e. has consistent appetite, not too picky)? Yes No

What does your child drink? water milk juice soda/caffeinated drinks

Any concerns about voiding or stooling? (i.e. constipation, bedwetting) Yes No

Do you have any concerns regarding your child's growth or puberty? Yes No

Females: Started menstruating? Yes No If Yes, any problems? Yes No

Have you discussed puberty/sexuality with your child? Yes No

Does your child have any problems with sleep? Yes No

How many hours of sleep does your child get each night? _____

School:

What school does your child attend? _____ Grade _____

What are your child's grades usually? _____

Do you have any concerns regarding your child's school performance? Yes No

Does your child have any problems with bullying/cyberbullying? Yes No

Social/Behavior:

Are there any family or home issues we should discuss? Yes No

Any concerns about your child's behavior (i.e. anxiety, mood swings)? Yes No

Are there problems with discipline? Yes No

Does your child have close friends or make friends easily? Yes No

Do you approve of your child's friends? Yes No

Is your child exposed to: Smoking Alcohol Drugs Any concerns? Yes No

Safety/Preventative Health:

Does your child always buckle his/her seatbelt? Yes No

Has your child seen a dentist in the last 6 months? Yes No

Does your child always wear a helmet when riding bike/scooter/skiing/etc? Yes No

Do you own a gun? Yes No If yes, is it stored safely (i.e. locked case)? Yes No

Are your child's immunizations up to date? Yes No

Does your child have any allergies (that you know of)? Yes No

Please list any medications or supplements your child took this week: _____