PT ID: ___________________
PCP: ____________________
Today's Date: ____________

Patient's Name: __________________________
Date of Birth: ____________________________

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 any 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:_____________________________________

Please have you child answer the following questions:

*Have you wished you were dead or wished you could go to sleep and not wake up? ....YES NO
*Have you had any actual thoughts of killing yourself? ....YES NO

If you answered "YES" to the last 2 questions, please see more questions on back of page

Have you been thinking about how you might do this? ………………………………………………………………………..YES NO
e.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it… and I would never go through with it"

Have you had these thoughts and had some intention of acting on them? ……………………………………….YES NO
as opposed to "I have the thoughts but I definitely will not do anything about them"

Have you started to work out or worked out the details of how to kill yourself?................................ YES NO
Do you intend to carry out this plan?... YES NO

Have you ever done anything, started to do anything, or prepared to do anything to end your life? ………..YES NO
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took the pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If YES: Was this within the past 3 months? ……………………………………………………………………………………YES NO