Name________________________ Today's Date_________
Date of Birth __________________

TB Screening Questionnaire (administer at 2 months, 6 months, 12 months, 18 months, 24 months, then yearly)

	YES	NO	UNSURE
Has your child been in close contact with a person with infectious Tuberculosis?			
Does your child have HIV infection or is considered at risk for HIV infection?			
Is your child foreign born (especially if born in Asia, Africa, or Latin America), a refugee, or an immigrant?			
Is your child in contact with the following individuals: HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?			
Does your child have a depressed immune system, either because of disease or treatment for disease?			
Does your child live in an established "high risk for tuberculosis" community or area?			

Cholesterol Risk Assessment Questionnaire (administer yearly from 2 to 18 years)

	YES	NO	UNSURE
Does your child have risk factors for future heart disease such as physically inactivity, diabetes, or obesity?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease (like heart attack or stroke) below age 55?			
Is there a family history (parents and grandparents) of elevated cholesterol?			

Hunger Vital Sign Questionnaire: (NB then yearly)
For each statement, please tell me whether the statement was Often True, Sometimes True, or Never True for your household in the past 12 months.

	Often True	**Sometimes True**	**Never True**
Within the past 12 months, we worried whether our food would run out before we got money to buy more.			
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.			

Patient Health Questionnaire: modified

Name: ____________ **Clinician:** ___________ **Date:** ___

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks?** For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little enerav?				
6. Feeling bad about yourself-or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite– being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

[] Yes [ ] No

If you are experiencing any of the problems on this form, 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

Has tllere been a time in the **past month** when you have had serious thoughts about ending your life?

[] Yes [] No

Have you **EVER,** in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes [] No

****If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.***

Office use only: Severity score: ____

Modified from the PHQ-9 [Modified from PRIME-MD PHQ-9 ®. Copyright© 1999 Pfizer Inc. (Spitzer et al, JAMA, 1999)], Revised PHQ-A (Johnson, 2002), and the Columbia DDS (DISC Development Gr oup, 2000)

Name: ________________________ Date: _____________

Date of Birth: _________________

The CRAFFT Screening Questions

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"	☐	☐

If the patient answered NO to ALL of the questions in Part A, ask the CAR question only. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:

The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

© Children's Hospital Boston, 2009.

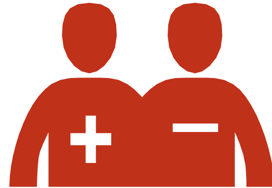
Reproduced with permission from the Center for Adolescent Substance Abuse Research, CeASAR, Children's Hospital Boston.

HIV Testing 101

Many HIV tests are now quick, FREE, and painless.

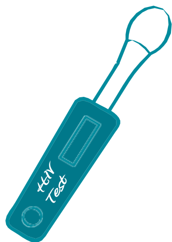
Should I Get Tested For HIV?

- Everyone ages 13 to 64 should get tested for HIV at least once.
- Some sexually active gay and bisexual men may benefit from more frequent testing (every 3 to 6 months).
- If you're pregnant or planning to get pregnant, get tested as early as possible to protect your baby.



- You should get tested at least once a year if:
  - You're a sexually active gay or bisexual man.
  - You've had sex with an HIV-positive partner.
  - You've had more than one partner since your last HIV test.
  - You've shared needles or works to inject drugs.
  - You've exchanged sex for drugs or money.
  - You have another sexually transmitted disease, hepatitis, or tuberculosis.
  - You've had sex with anyone who has done anything listed above or with someone whose sexual history you don't know.

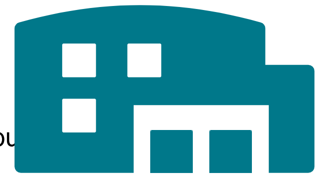
Where Can I Get Tested?



Ask your doctor for an HIV test, or find a testing site near you by

- visiting gettested.cdc.gov,
- texting your ZIP code to KNOW IT (566948), or
- calling 1-800-CDC-INFO (232-4636).

Many testing locations are FREE and confidential. You can also bu a home testing kit at a pharmacy or online. Most HIV tests are covered by health insurance.



What If My Test Result Is Negative?

- You could still have HIV. Ask your doctor about the "window period," a period of time after a person is infected during which they won't test positive.
- To stay negative, take actions to prevent HIV.

Visit www.cdc.gov/hiv/basics to learn more.

What If My Test Result Is Positive?

You may be given a follow-up test to confirm the result.

- Finding out you have HIV can be scary, but you can still live a healthy life if you take action.
- If you have HIV, start medical care right away. HIV treatment can keep you healthy for many years and reduce your chance of transmitting the virus to others. Learn more at www.cdc.gov/HIVTreatmentWorks.

For more information please visit www.cdc.gov/hiv

January 2017

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

CDC

Bright Futures Parent Handout
15 to 17 Year Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

PHYSICAL GROWTH AND DEVELOPMENT

Your Growing and Changing Teen

- Help your teen visit the dentist at least twice a year.
- Encourage your teen to protect her hearing at work, home, and concerts.
- Keep a variety of healthy foods at home.
- Help your teen get enough calcium.
- Encourage 1 hour of vigorous physical activity a day.
- Praise your teen when he does something well, not just when he looks good.

RISK REDUCTION

Healthy Behavior Choices

- Talk with your teen about your values and your expectations on drinking, drug use, tobacco use, driving, and sex.
- Be there for your teen when she needs support or help in making healthy decision about her sexual behavior.
- Support safe activities at school and in the community.
- Praise your teen for healthy decisions about sex, tobacco, alcohol, and other drugs.

VIOLENCE AND INJURY PREVENTION

Violence and Injuries

- Do not tolerate drinking and driving.
- Insist that seat belts be used by everyone.
- Set expectations for safe driving.
  - Limit the number of friends in the car, nighttime driving, and distractions.
- Never allow physical harm of yourself, your teen, or others at home or school.
- Remove guns from your home. If you must keep a gun in your home, make sure it is unloaded and locked with ammunition locked in a separate place.
- Teach your teen how to deal with conflict without using violence.
- Make sure your teen understands that healthy dating relationships are built on respect and that saying "no" is OK.

EMOTIONAL WELL-BEING

Feelings and Family

- Set aside time to be with your teen and really listen to his hopes and concerns.
- Support your teen as he figures out ways to deal with stress.
- Support your teen in solving problems and making decisions.
- If you are concerned that your teen is sad, depressed, nervous, irritable, hopeless, or angry, talk with me.

SOCIAL AND ACADEMIC COMPETENCE

School and Friends

- Praise positive efforts and success in school and other activities.
- Encourage reading.
- Help your teen find new activities she enjoys.
- Encourage your teen to help others in the community.
- Help your teen find and be a part of positive after-school activities and sports.
- Encourage healthy friendships and fun, safe things to do with friends.
- Know your teen's friends and their parents, where your teen is, and what he is doing at all times.
- Check in with your teen's teacher about her grades on tests.
  - Attend back-to-school events if possible.
  - Attend parent-teacher conferences if possible.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit.* Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.