

Name _____
 Date of Birth _____

Today's Date _____

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 energy?				
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 there 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: _____

Name: _____

Date: _____

Date of Birth: _____

The CRAFFT Screening Questions

Part A

During the PAST 12 MONTHS, did you:

- | | No | Yes |
|---|--------------------------|--------------------------|
| 1. Drink any <u>alcohol</u> (more than a few sips)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Smoke any <u>marijuana or hashish</u> ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Use <u>anything else</u> to <u>get high</u> ? | <input type="checkbox"/> | <input type="checkbox"/> |

“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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you ever use alcohol or drugs while you are by yourself, or ALONE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you ever FORGET things you did while using alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever gotten into TROUBLE while you were using alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |

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.



Bright Futures Parent Handout Early Adolescent Visits

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

Your Growing and Changing Child

PHYSICAL GROWTH AND DEVELOPMENT

- Talk with your child about how her body is changing with puberty.
- Encourage your child to brush his teeth twice a day and floss once a day.
- Help your child get to the dentist twice a year.
- Serve healthy food and eat together as a family often.
- Encourage your child to get 1 hour of vigorous physical activity every day.
- Help your child limit screen time (TV, video games, or computer) to 2 hours a day, not including homework time.
- Praise your child when she does something well, not just when she looks good.

Healthy Behavior Choices

RISK REDUCTION

- Help your child find fun, safe things to do.
- Make sure your child knows how you feel about alcohol and drug use.
- Consider a plan to make sure your child or his friends cannot get alcohol or prescription drugs in your home.
- Talk about relationships, sex, and values.
- Encourage your child not to have sex.
- If you are uncomfortable talking about puberty or sexual pressures with your child, please ask me or others you trust for reliable information that can help you.
- Use clear and consistent rules and discipline with your child.
- Be a role model for healthy behavior choices.

Feeling Happy

EMOTIONAL WELL-BEING

- Encourage your child to think through problems herself with your support.
- Help your child figure out healthy ways to deal with stress.
- Spend time with your child.
- Know your child's friends and their parents, where your child is, and what he is doing at all times.
- Show your child how to use talk to share feelings and handle disputes.
- If you are concerned that your child is sad, depressed, nervous, irritable, hopeless, or angry, talk with me.

School and Friends

SOCIAL AND ACADEMIC COMPETENCE

- Check in with your child's teacher about her grades on tests and attend back-to-school events and parent-teacher conferences if possible.
- Talk with your child as she takes over responsibility for schoolwork.
- Help your child with organizing time, if he needs it.
- Encourage reading.
- Help your child find activities she is really interested in, besides schoolwork.
- Help your child find and try activities that help others.
- Give your child the chance to make more of his own decisions as he grows older.

Violence and Injuries

VIOLENCE AND INJURY PREVENTION

- Make sure everyone always wears a seat belt in the car.
- Do not allow your child to ride ATVs.
- Make sure your child knows how to get help if he is feeling unsafe.
- 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.
- Help your child figure out nonviolent ways to handle anger or fear.



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