PEDIATRIC AND ADOLESCENT HEALTH PARTNERS

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient name: *(Last, First, M.I.)::*	☐ M ☐ F ☐ Identify as:______	**Patient DOB:**
Primary caregiver *(Last, First, M.I.):*		**Today's date:**
Parental marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Custody status:	**Household members:**	
Previous or referring doctor:	**Date of last physical exam:**	

PATIENT BIRTH HISTORY

☐ Check here if unchanged since last visit

Birth Weight:		**Pregnancy Number**	
Delivery Type:	☐ Vaginal ☐ C-Section	**Feeding preference:**	☐ Breastmilk ☐ Formula
Gestational Age:	☐ Term ☐ Preterm ☐ Late term	**Parental Age:**	☐ Mother ☐ Father
Pregnancy Complications:		**Delivery Complications:**	
At any point during the pregnancy, did the patient's mother use?		☐ Illicit drugs ☐ Alcohol ☐ Prescription medicine	List here:

Immunizations:

☐ Up To Date ☐ Delayed

Surgeries

Year	Reason	Hospital/ Surgeon

Hospitalizations

Year	Reason	Hospital/ Surgeon

List your child's prescribed medications, over-the-counter medications, vitamins, and inhalers

Name of medication	Reason	Dosage and frequency

Medication and food allergies

Allergen	Reaction	Do you have an epinephrine injector?
		☐ Epipen
		☐ Auvi-Q
		☐ Adrenaclick
		☐ Other List:

Please check below if your child or an immediate family member has a history of any of the following medical conditions?		
Check here if unchanged since prior well visit:		☐
Condition	Child	Family Member (Mom, Dad, Sibling, Grandparent)
Asthma, reactive airway, or chronic bronchitis		Relative:
Seasonal allergies		Relative:
Eczema/Psoriasis		Relative:
Vision Problems or hearing difficulty		Relative:
Frequent headaches or migraines		Relative:
Stroke or heart attack		Relative:
Heart disease		Relative:
Heart murmur		Relative:
Hypo/Hyperthyroidism		Relative:
Chronic UTI or kidney disease		Relative:
ADHD/Anxiety/Depression		Relative:
Autism/Down Syndrome/Developmental Delay		Relative:
Tobacco/Alcohol/Drug abuse or exposure		Relative:
Cancer		Relative:
Other: Please specify		Relative:

ACUTE CONCERNS

Has your child been to the emergency room since last visit?	☐ Yes	Reason:	☐ No
Has your child been admitted to the hospital since the last visit?	☐ Yes	Reason:	☐ No
Has your child been to a specialist since the last visit?	☐ Yes Specialist:	Reason:	☐ No
Do you need paperwork completed at today's visit?	☐ Yes		☐ No
What are the top two areas of concern that you would like addressed today:	1.		2.

Are any of the following issues worrying your family or your child at this time?

☐ Sexual abuse		☐ Sickness or death of a loved one	☐ Recent separation or divorce
☐ Substance abuse		☐ Grief	☐ Lay-off or unemployment
☐ Domestic abuse	☐ Physical ☐ Verbal	☐ New job or change in position	☐ Financial Struggles
☐ Other:		☐ Explain here:	☐

EMOTIONAL HEALTH SCREENING

We ask the following questions because we know that exposure to adversity is common and can have an impact on your child's physical and emotional health. We understand that these questions can be difficult to answer, please ask your provider or office staff if you would like to discuss anything privately.

Please do not mark or specify which specific statements apply to your child. Document the number of positive answers only.

Of the statements in Section 1(below), HOW MANY apply to your child?	
Section 1:	**Total Positives:_______**
At any point since your child was born….	
• Your child's parents or guardians were separated or divorced	
• Your child lived with a household member who served time in jail or prison	
• Your child lived with a household member who was depressed, mentally ill, or attempted suicide	
• Your child saw or heard household members hurt or threaten to hurt each other	
• A household member swore at, insulted, humiliated or put down your child in a way that scared your child OR a household member acted in a way where your child felt scared that he/she may be physically hurt	
• Someone touched your child's private parts or asked to touch your child's private parts in a sexual way	
• More than once, your child went without food, clothing, a place to live, or had no one to protect her/him	
• Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks	
• Your child lived with someone who had a problem with drinking or using drugs	
• Your child often felt unsupported, unloved and/or unprotected	
Of the statements in Section 2(below), HOW MANY apply to your child?	
Section 2:	**Total Positives:_______**
At any point since your child was born…	
• Your child was in foster care	
• Your child experienced harassment or bullying at school	
• Your child lived with a parent or guardian who died	
• Your child was separated from her/his primary caregiver through deportation or immigration	
• Your child had a serious medical procedure or life threatening illness	
• Your child often saw or heard violence in the neighborhood or in her/his school neighborhood	
• Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion	

CYW ACE-Q Child (0-12 yo) © Center for Youth Wellness 2015

Would you like to speak to a staff member about resources that you feel your family needs or may be lacking?

- ☐ Yes
- ☐ No

If so, please list your preferred contact information:

Phone:
Email:

Please let us know if there is anything that you feel that we could help you with today. If we are unable to help immediately, we will work with you to find the answer to your question or help that you need.