HEALTHY HABITS ASSESSMENT

Children's Healthcare of Atlanta

ild's Name

te of Birth

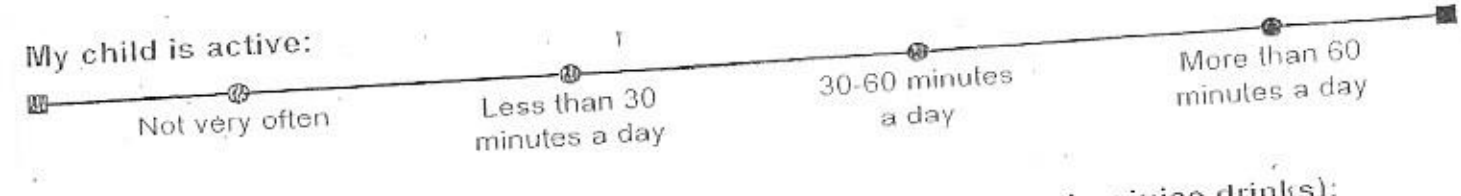
Date

Circle the answer that best describes your child's average eating and activity habits.

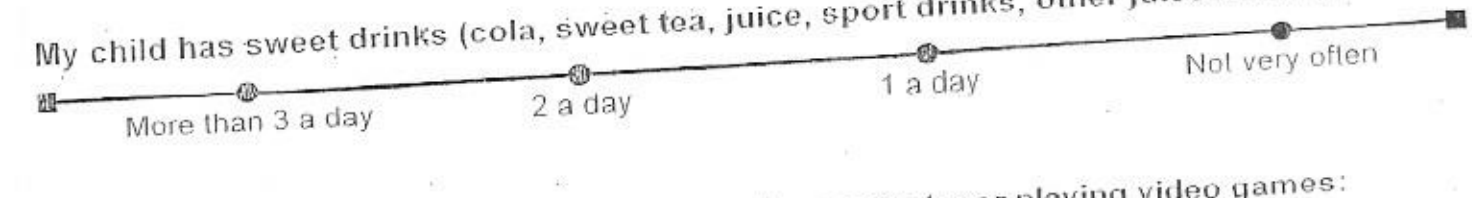
My child eats veggies and fruits:

My child eats out:

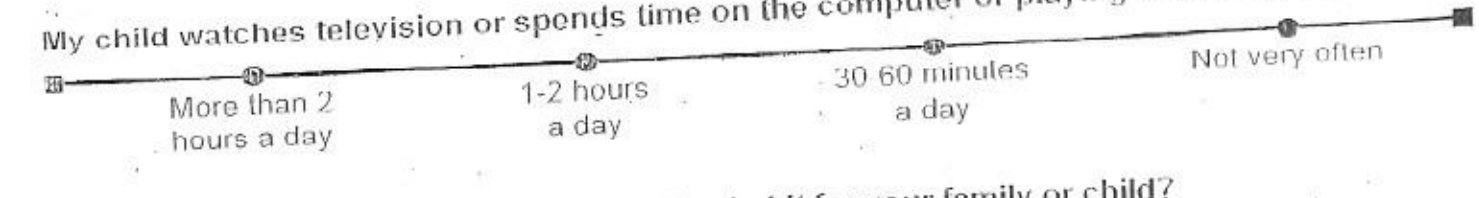
My child is active:



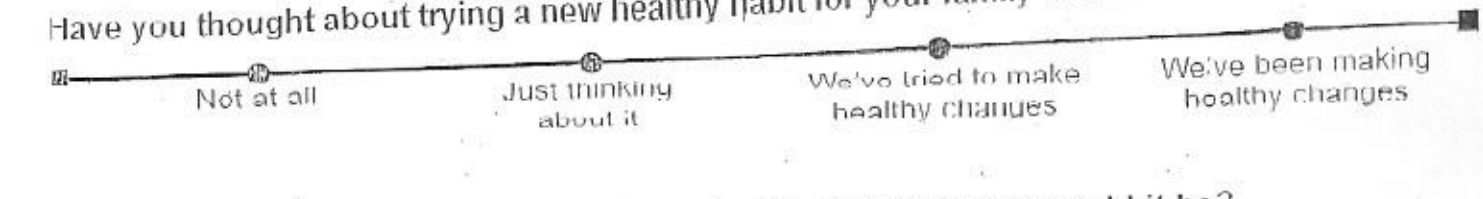
My child has sweet drinks (cola, sweet tea, juice, sport drinks, other juice drinks):



My child watches television or spends time on the computer or playing video games:



Have you thought about trying a new healthy habit for your family or child?



If you could work on one healthy habit, which would it be?

- ❑ Fill half your plate with veggies & fruits
- ❑ Limit screen time to one hour
- ❑ Be active for 60 minutes
- ❑ Drink more water and limit sugar drinks

GEORGIA WIC

PHQ9P

PATIENT HEALTH QUESTIONNAIRE

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? No ☐ *(provide reason in comments)*

If Yes, data collected on visit date ☐ or specify date: ________ DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

SCORING FOR USE BY STUDY PERSONNEL ONLY

__0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

I confirm this information is accurate.	Patient's/Subject's Initials:	Date:

Bright Futures

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name:

11-14 years DOB:

Bright Futures Previsit Questionnaire
Early Adolescent Visits

Bright Futures

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Do you live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ Teeth ☐ Appearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ How your body is changing ☐ Your weight
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable
Healthy Behavior Choices	☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Pregnancy ☐ Sexually transmitted infections (STIs) ☐ Decisions about sex and drugs
Violence and Injuries	☐ Car safety ☐ Using a helmet or protective gear ☐ Keeping yourself safe in a risky situation ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Have you ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Growing and Developing

Check off all of the items that you feel are true for you.

- ☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ☐ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ☐ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ☐ I am able to bounce back from life's disappointments.
- ☐ I have a sense of hopefulness and self-confidence.
- ☐ I have become more independent and made more of my own decisions as I have become older.
- ☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Bright Futures.

Bright Futures Previsit Questionnaire
Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? _____

Questions About Your Child

Vision	Does your child complain that the blackboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Has your child ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Does your child hold books close to read?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Does your child tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Does your child have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Does your child ask people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Does your child misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your child's period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Your Growing and Developing Child

Check off all of the items that you feel are true for your child.

- ☐ My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe.
- ☐ My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
- ☐ My child has at least one friend or a group of friends with whom she is comfortable.
- ☐ My child helps others individually or by working with a group in school, a faith-based organization, or the community.
- ☐ My child is able to bounce back from life's disappointments.
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- ☐ My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe: