



### Risk Assessment 11-14 Years

Do you:

- Have at least one responsible adult in life who cares and can go to if needed for help      Yes    No    Comment
- Have at least one friend or group of friends with whom you are comfortable      Yes    No    Comment
- Have you become more independent and made more of his/her own decisions      Yes    No    Comment
- Have concerns about body image?      Yes    No    Comment
- Is blackboard at school difficult to see      No    Yes    Comment
- Has child failed a school vision screen      No    Yes    Comment
- Does your child tend to squint      No    Yes    Comment
- Does child have problems hearing over the telephone      No    Yes    Comment
- Does child ask people to repeat themselves      No    Yes    Comment

Servings of fruit & vegetables per day	More than 4 per day	3-4 per day	1-2 per day	0-1 per day
Eats out each week	0-1 times	1-2 times	3-4 times	More than 4 times
Activity level	More than 60 min per day	30-60 min per day	Less than 30 min per day	Not very often
Sweet drinks per day	Not very often	1 per day	2 per day	More than 3 per day
TV/screen time	Not very often	30-60 min/d	1-2hr/d	More than 2hr/d

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**TB RISK**

- Born in country outside of the United States      No    Yes    Comment
- Traveled or had contact with high TB risk populations longer than a week      No    Yes    Unknown    Comment
- Family member or contact had tuberculosis or positive TB skin test.      No    Yes    Unknown    Comment
- Is the child HIV infected      No    Yes    Unknown    Comment

**ANEMIA RISK**

- Diet includes iron-rich foods such as meat, eggs, iron fortified cereal, or beans      Yes    No    Comment
- Has child ever been diagnosed with iron deficiency anemia      No    Yes    Comment
- Females; Does child have excessive menstrual bleeding or other blood loss      No    Yes    Comment    N/A
- Females: Does child's period last more than 5 days      No    Yes    Comment    N/A
- Does child live in parents' home      Yes    Sometimes    No

Do you eat meals together as a family at least once per week	Yes	No	Comment
Have you discussed physical and emotional changes of puberty with your child	Yes	No	Comment
Does child have TV in bedroom	No	Yes	Comment
Does child go to school	Yes	No	Comment
Having any problems in school	No	Sometimes	Yes
Is doing well in school important to you and your child	Yes	No	Comment
Do you know your child's friends and their families	Yes	No	Comment
Always wears a seat belt when riding in car, truck or van	Yes	Sometimes	No
Wears helmet/protective gear when biking, skating, skiing, or snowboarding	Yes	Sometimes	No
Does child wear protective gear when playing team sports	Yes	No	Comment
Do you praise child when he does something good or learns something new	Yes	No	Comment
Do you spend time talking to your child everyday	Yes	No	Comment
Do you talk to your child about relationships and sex	Yes	No	Comment
Do you talk to your child about alcohol and drugs	Yes	No	Comment
Does anyone you live with smoke cigarettes/cigars or use chewing tobacco?	No	Sometimes	Yes

**Cardiac Risk: Has your child ever had:**

Fainting during or after exercise, emotion or startle?	No	Yes
Extreme shortness of breath with exercise?	No	Yes
Discomfort, pain or pressure in chest during exercise?	No	Yes

## The Patient Health Questionnaire-2 (PHQ-2)

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

Over the past 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