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: How old was your daughter when she had her first period (menarche)? Age____ N/A			Comment	N/A
What was the date of your daughter's last menstrual period? Date _____ N/A				
Females; Does child have excessive menstrual bleeding or other blood loss	No	Yes	Comment	N/A

Females: Does child's period last more than 7 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