Pediatric Professional Associates

Parent Questionnaire

Date: _____

Patient Name:_____**DOB**: _____

Are your child's parents: ☐ Married ☐ Unmarried ☐ Separate ☐ Divorced ☐ Widowed

Date of Separation/Divorce: _____

Concerns about your child (please check all that apply):

- *Alcohol/Drug Use*
- *Tobacco*
- *Sexual Activity*
- *Behaviors*
- *Mood/Emotions*
- *learning ability*
- *body is growing*
- *getting along with others*

Is violence at home a concern? ☐ Yes ☐

No Are there pets in the home? ☐Yes

☐ No Are there guns in the home?

☐Yes ☐ No Do any family members

smoke? ☐Yes ☐ No

Any concerns regarding how much/ what kinds of foods is your child eating? ☐

Yes ☐ NoAny concerns regarding how much sleep your child is getting nightly? ☐

Yes ☐ No

Are there any problems in your home that might affect your child? ☐ *Yes* ☐ *No*

Are there any issues that make it hard for you to provide for your child's health? ☐ *Yes* ☐ *No*

Does your child spend more than 2 hours per day of TV/computer/electronic time? ☐ *Yes* ☐

No