Teen/Parent Questionnaire
(12-17 y/o)

Patient's Name: _____ Today's Date: _____
Teen's cell phone: _____ Completed by: _____

Please answer the questions so we can help you set **goals for your child's health**

Do you have any questions about injury prevention? If yes, please circle

seatbelt	sports safety	texting/media safety
bullying	dating	sexual behavior
driving	alcohol/cigarette/substance use	

How many hours/day does your child spend in front of TV/computer/video games?
* Limit screen time to 2 hours/day

Do you have any concerns regarding your child's eating habits? If yes, please circle

5 servings of fruits/vegetables	protein	fast foods
dairy/calcium/vitamin D	soda/sweet drinks	
unhealthy snacks or portion size	body image perception	

* Family should eat meals together at least 3-4x/week with TV off
* For healthy eating, go to ***www.choosemyplate.gov***

Does your child engage in exercise at least 30 minutes/day, 5 days/week? Yes No

Do you have any concerns about your child's development? If yes, please circle

school/learning	behaviors	moods/emotions	sleep
growth	other		

Are there any problems at home or school that might affect your child? Yes No

Are there things that make it hard for you to take care of your child's health that you would like to discuss? Yes No

Any other concerns?

PHQ2: Over the past 2 weeks, how often have you been bothered by any of the following problems: please circle 0, 1, 2 or 3

	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