The Smarter Choice for Care

Middlesex Health



11-14 Year Well-Child Visit

Pre-Appointment Paperwork

Please complete the following forms prior to your/your child's upcoming well-child visit. All forms are fillable PDFs that can be completed on your computer/smartphone, or you can print this packet and fill it in by hand.

If you are coming to our office, please bring these forms to the appointment.

If you have scheduled a virtual visit, please email the completed forms to your provider's office. Provider emails are available at middlesexhealth.org/wellchild.

We look forward to seeing you soon!

Updated: khc, 9/23/2020

Name: _____ DOB:_____ Date:_____

PHQ9: How often have you been bothered by each of the following symptoms during the past two weeks? Circle answer	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, irritable, or hopeless?	0 ☐	1 ☐	2 ☐	3 ☐
Little interest or pleasure in doing things?	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling asleep, staying asleep, or sleeping too much?	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite, weight loss, or overeating?	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired, or having little energy?	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on things like school work, reading, or TV?	0 ☐	1 ☐	2 ☐	3 ☐
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?	0 ☐	1 ☐	2 ☐	3 ☐
Thoughts that you would be better off dead, or of hurting yourself in some way?	0 ☐	1 ☐	2 ☐	3 ☐
If you are experiencing any of the problems on this form, 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	

SCARED: Below is a list of sentences that describe how people feel. Read each phrase and circle the number that corresponds to what describes you over the past 3 months.	Not true or hardly ever true	Somewhat true or sometimes true	Very true or often true
I am frightened for no reason all all	0 ☐	1 ☐	2 ☐
I am afraid to be alone in the house	0 ☐	1 ☐	2 ☐
People tell me I worry too much	0 ☐	1 ☐	2 ☐
I am scared to go to school	0 ☐	1 ☐	2 ☐
I am shy	0 ☐	1 ☐	2 ☐

2.1 CRAFFT SCREENING QUESTIONS. Please answer honestly your answers will be kept confidential. During the **PAST 12 MONTHS**, on how many days did you:	# of DAYS Put "0" if none.
1. Drink more than a few sips of beer, wine or any drink containing **alcohol**?	
2. Use any **marijuana** (weed, oil, or hash by smoking, vaping or in food) or "**synthetic marijuana**" (like "K2", "Spice"?)	
3. Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff or vape)?	
READ THESE INSTRUCTIONS BEFORE CONTINUING: If you put 0 in all of the boxes above answer question 4 THEN STOP. If you put 1 of higher in any of the boxes above, ANSWER QUESTIONS 4-9	CHOOSE ONE
4. Have you ever ridden in a **CAR** drive by someone (including yourself) who was high or had been using alcohol or drugs?	YES ☐ NO ☐
5. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	YES ☐ NO ☐
6. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	YES ☐ NO ☐
7. Do you ever **FORGET** things you did while using alcohol or drugs?	YES ☐ NO ☐
8. Do your **FAMILY or FRIENDS** ever tell you that you should cut down on drinking or drug use?	YES ☐ NO ☐
9. Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?	YES ☐ NO ☐

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5.2.1.0. Healthy Habits Questionnaire (Ages 11-21)

We are interested in the well-being of all of our patients. Please take a moment to answer the following questions.

NAME: **DOB:** **TODAY'S DATE:**

OVERALL ON A SCALE FROM 1-10, how would you rate your health? (1 = Poor, 10 = Excellent)

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1. **FRUITS AND VEGGIES:**
   Do you eat 5 servings of fruits and vegetables per day? ◯ **YES** ◯ **NO**

2. **SUGARY DRINKS/JUICE:**
   Do you drink juice, sports drinks, iced tea, lemonade, sweetened beverages most days? ◯ **YES** ◯ **NO**

3. **SCREEN TIME:**
   Do you watch more than 2 hours per day of TV, movies, videos, tablets, or phone? ◯ **YES** ◯ **NO**

4. **EXERCISE:**
   Do you spend at least 1 hour per day exercising or playing sports (sweating)? ◯ **YES** ◯ **NO**

5. **SNACKS:**
   How many times per day do you eat snack food (chips, candy, pretzels, goldfish, gummy snacks, crackers, cookies)?

   ◯ **1** ◯ **2** ◯ **3** ◯ **4 or more**

6. **Based on your answers, is there <u>ONE</u> thing you would like to change? Please check <u>ONE</u> box.**

   ☐ Eat more fruits and vegetables ☐ Watch less screen time ☐ Eat less snack food

   ☐ Drink more water ☐ Exercise more ☐ Drink less juice or soda

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Teen Self-Report

To be completed by Patient

Today's Date: _____

Your Name: _____ Date of birth: _____

Many children experience stressful life events that can affect their health and development. The results from this questionnaire will assist your doctor in assessing your health and determining guidance. Please read the statements below. Count the number of statements that apply to you and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to you.

1) Of the statements in section 1, HOW MANY apply to you? Write the total number in the box. ☐

Section 1. *At any point since you were born…*

- Your parents or guardians were separated or divorced
- You lived with a household member who served time in jail or prison
- You lived with a household member who was depressed, mentally ill or attempted suicide
- You saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- More than once, you went without food, clothing, a place to live, or had no one to protect you
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- You lived with someone who had a problem with drinking or using drugs
- You often felt unsupported, unloved and/or unprotected

2) Of the statements in section 2, HOW MANY apply to you? Write the total number in the box. ☐

Section 2. *At any point since you were born…*

- You have been in foster care
- You have experienced harassment or bullying at school
- You have lived with a parent or guardian who died
- You have been separated from your primary caregiver through deportation or immigration
- You have had a serious medical procedure or life threatening illness
- You have often seen or heard violence in the neighborhood or in your school neighborhood
- You have been detained, arrested or incarcerated
- You have often been treated badly because of race, sexual orientation, place of birth, disability or religion
- You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

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QUESTIONS FOR TEENS (11-21 Years)

Your answers will be kept confidential.

Part I: Please answer the following questions.

1. Have you vaped, juuled, or used an electronic cigarette in the past year?
   If yes, # of days:

2. Have you vaped in the past month? If yes, # of days:

3. How many times per day do you vape? # of times per day

Part II: Stressful events like trouble getting food, violence, or loss are common and can affect the health of many young people. By answering the following questions, you can help your provider better understand you. You may choose to answer them or not.

Has anyone hurt or frightened you recently or in the last year?

- ☐ Yes
- ☐ No

Has anything bad, sad or scary happened to you recently or in the last year?

- ☐ Yes
- ☐ No

Within the past 12 months, we worried whether our food would run out before we got money to buy more.

- ☐ Never True
- ☐ Sometimes True
- ☐ Often True

Within the past 12 months, the food we bought just didn't last and we didn't have money to buy more.

- ☐ Never True
- ☐ Sometimes True
- ☐ Often True