The Smarter Choice for Care
Middlesex Health

7-8 Year Well-Child Visit
Pre-Appointment Paperwork

Please complete the following forms prior to 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!

Child's Name: ____________________________ Date of Birth: ______________________

Filled out by: ______________________________ Today's Date: ______________________

Pediatric Symptom Checklist-17 (PSC-17)
Parent Assist (Ages 6-10)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best describes your child:

	(0) NEVER	(1) SOMETIMES	(2) OFTEN
1. Feels sad, unhappy	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Is down on self	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if driven by a motor	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not understand other people's feelings	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Refuses to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐
		NO	**YES**
18. Does your child have any emotional or behavioral problems for which she/he needs help?		☐	☐

For office use only

Total Qs 1-5_____ **Total Qs 6-10**_____ **Total Qs 11-17**_____ **Total Qs 1-17**_____

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5.2.1.0. Healthy Habits Questionnaire (Ages 2-10)

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

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

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

1 2 3 4 5 6 7 8 9 10

1. **FRUITS AND VEGGIES:**
   Does your child eat 5 servings of fruits and vegetables per day? **YES NO**

2. **SUGARY DRINKS/JUICE:**
   Does your child drink juice, sports drinks, iced tea, lemonade, sweetened beverages most days? **YES NO**

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

4. **EXERCISE:**
   Does your child spend at least 1 hour per day actively playing or exercising (sweating)? **YES NO**

5. **SNACKS:**
   How many times per day does your child eat snack food (kid's yogurts, pouches, pretzels, goldfish, gummy snacks, crackers, cookies, chips)?

   1 2 3 4 or more

6. **Based on your answers, is there ONE thing you would like to help your child change now? Please check one box.**

Eat more fruits and vegetables	Watch less screen time	Eat less snack foods
Drink more water	Exercise more	Less juice or soda

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: ___________________________________

Child's Name: ____ *Date of birth:* ___________________________________

Your Name: ____ *Relationship to Child:* ____________________________

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

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

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born…*

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

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born…*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Middlesex Health

PARENT QUESTIONS FOR CHILDREN 6-11 YEARS OLD

Stressful events like trouble getting food, violence, or loss are common and can affect your child's health and development. To provide the best care, we ask all families about their experiences.

You may choose to answer these or not.

CHILD'S NAME: **CHILD'S DOB:**

1. Has anyone hurt or frightened you or your child recently or in the last year?
   - ❏ Yes
   - ❏ No

2. Has anything bad, sad or scary happened to your child recently or in the last year?
   - ❏ Yes
   - ❏ No

3. 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

4. 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