Whole Child Assessment- Version 3 for 12 – 17 Years PARENT FORM

Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. ***You may skip any question if you do not know an answer or do not want to answer.*** *You may add comments to explain your answers. We will keep this information confidential, unless there is concern that your child is being hurt.*

1	Person completing form	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*	
2a	What grade is your child in school?	6 7 8 9 10 11 12	Interval History
2b	Are your child's grades below average?	No / Unsure / Yes	
2c	Does your child participate in special ed or have a school IEP/504 plan?	No / Unsure / Yes	
3	Since the last visit, has your child • Been seen in another clinic? • Developed a new illness? • Been seen in the Emergency Room? • Been hospitalized? • Had an operation?	No / Unsure / Yes No / Unsure / Yes No / Unsure / Yes No / Unsure / Yes No / Unsure / Yes	
4	Do you have any questions or concerns about your child's growth or behavior? *If yes, please describe:*	No / Unsure / Yes	
5	Has a family member or close contact had tuberculosis disease during your child's lifetime?	No / Unsure / Yes	Tuberculosis
6	Was your child born in the United States?	Yes / Unsure / No	
7	Has your child lived or traveled outside of the United States for at least a **month**?	No / Unsure / Yes	
8	In the past year, has your child been seen twice by a dentist?	Yes / Unsure / No	Dental
9	Do you find you need to shout or yell at your child?	Never / Sometimes / Often	Relationships
10	Are your child's parents separated, divorced, or not living together?	No / Deceased parent / Unsure / Yes	
11	Did a parent or household member get arrested, deported, go to prison, jail, or another correctional facility during your child's lifetime?	No / Unsure / Yes	
12	Do you know or are you concerned that anyone touched your child, or forced your child to touch that person, in a sexual way?	No / Unsure / Yes	
13	Was a parent or household member **ever** depressed, mentally ill, **OR** suicidal?	No / Unsure / Yes	Mental Health
14	Did a parent or household member **ever** have a problem with drugs **OR** alcohol?	No / Unsure / Yes	Substances
15	Does your home have a working smoke detector and carbon monoxide detector?	Yes / Unsure / No	Safety
16	Does your child spend time with anyone who carries a weapon, or spend time in a home where a gun is kept?	No / Unsure / Yes	
17	Has your child (as a baby or when older) **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No / Unsure / Yes	

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18	Has your child **ever** lived with a parent or other adult who physically hurt the child in anger?	No	Unsure	Yes	
19	On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the **last year**?	Not at all	A little	Somewhat	Fairly Very
20	Would you like someone to follow-up with you about community resources?	No	Unsure	Yes	

If you have additional concerns, comments, or questions, please describe here:

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THIS FORM SHOULD BE COMPLETED BY THE 12 TO 17 YEAR OLD PATIENT IF ABLE.

Please answer all the questions on this form as best you can. It will help us know how we can help you be healthy. ***You may skip any question if you do not know an answer or do not want to answer.*** *You may add comments to explain your answers. We will keep this information confidential, unless there is concern that you are being hurt.*

21	Person completing form	□ Self	If patient unable to complete, who helped fill out forms? □ Parent □ Friend □ Other *(specify)*			
	Do you live with…?	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*				
22	Do you have any questions or concerns about your growth or development? *If yes, please describe:*		No	Unsure	Yes	Interval History
23	Since the last visit, have there been any changes or events that were stressful, scary, or upsetting to you?		No	Unsure	Yes	
24	*Girls only*- Do you have any questions or concerns about your periods?		No	Unsure	Yes	
25	Do you brush your teeth twice daily with fluoride toothpaste?		Often	Sometimes	Never	9 Dental
26	How many servings of fruit (about the size of your fist) do you eat each **day**?		3+	2	0-1	8 Nutrition
27	How many servings of vegetables (about the size of your fist) do you eat each **day**?		4+	2-3	0-1	
28	How many servings a **day** do you drink or eat of calcium-rich foods, such as milk, cheese, yogurt, soy milk, **OR** tofu?		3+	2	0-1	
29	How many times a **day** do you drink a cup (about 8 oz) of juice, soda, sports drinks, energy drinks, **OR** other sweetened drinks?		0-1	2	3+	
30	How many times a **week** do you eat breakfast?		6-7	3-5	0-2	
31	How many times a **week** do you eat high-fat foods, such as fried foods, pizza, **OR** other fast food?		0-1	2-3	4+	
32	How many times a **week** do you snack on chips, pretzels, **OR** crackers?		0-1	2-3	4+	
33	How many times a **week** do you eat ice cream, cookies, **OR** other desserts?		0-1	2-3	4+	
34	How many times a **week** do you engage in moderate to strenuous exercise or physical activity (causes you to breathe hard or sweat)?		6-7	3-5	0-2	7 Physical Activity
35	On those days that you engage in moderate to strenuous exercise or physical activity, how many **minutes** to you exercise?		60+	30-59	0-29	
36	Outside of schoolwork, how many **hours a day** do you spend on screen time (TV, phone, computer, tablet, video games, etc.)?		0-1	2+ Sometimes	2+ Often	
37	Are you involved in sports, dance, music, religious activities, or other extracurriculars?		Yes	Unsure	No	

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38	Do you have trouble falling asleep or staying asleep?	Never	Sometimes		Often	6 Sleep
39	Did you **ever** live with anyone who **often** shouted or yelled at you?	No	Unsure		Yes	5 Relationships
40	Did you **ever** live with anyone who acted in a way that made you feel afraid?	No	Unsure		Yes	
41	Does your family look out for each other, feel close to each other, and support each other?	Often	Sometimes		Never	
42	Do you feel that your family loves you or thinks that you are important or special?	Often	Sometimes		Never	
43	Do you have someone you can count on to listen to you when you need to talk?	Yes	Unsure		No	
44	Have you ever been arrested or gone to jail or juvenile hall?	No	Unsure		Yes	
45	What sex were you assigned at birth?	❑ Female ❑ Male ❑ Don't know (not sure) ❑ Prefer not to answer				
46	What is your current gender identity?	❑ Female ❑ Male ❑ Nonbinary ❑ Other (another gender) ❑ Transgender female ❑ Transgender male ❑ Don't know (not sure) ❑ Prefer not to answer				
47	Do you think of yourself as…?	❑ Gay ❑ Lesbian ❑ Straight (heterosexual) ❑ Bisexual ❑ Pansexual ❑ Asexual ❑ Something else ❑ Don't know (not sure) ❑ Prefer not to answer				
48	Do you have any questions about sex, preventing pregnancy, or preventing infections from oral, vaginal, or anal sex?	No	Unsure		Yes	
49	Has anyone ever touched you in a way that was unwanted, or forced you to touch that person in a sexual way?	No	Unsure		Yes	
50	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	4 Mental Health
	A1. Little interest or pleasure in doing things	0	1	2	3	
	A2. Feeling down, depressed, or hopeless	0	1	2	3	A:
	B1. Feeling nervous, anxious, or on edge	0	1	2	3	
	B2. Not being able to stop or control worrying	0	1	2	3	B:
51a	In the past few weeks, have you wished you were dead?	No	Unsure		Yes	
51b	In the past few weeks, have you felt that you or your family would be better off if you were dead?	No	Unsure		Yes	
51c	In the past week, have you been having thoughts about killing yourself?	No	Unsure		Yes	
51d	Have you ever tried to kill yourself?	No	Unsure		Yes	

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52	Was your parent or anyone you **ever** lived with depressed, mentally ill, **OR** suicidal?	No	Unsure	Yes	
53	Do you smoke, vape, use e-cigarettes, chew tobacco, **OR** spend time with anyone who does?	No	Unsure	Yes	3 Substances
54	Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?	No	Unsure	Yes	
55a	How about you—during the **past 12 months**, on how many days did you drink more than a few sips of beer, wine, or any drinking containing alcohol?	0	1	2+	
55b	During the **past 12 months**, on how many days did you use any marijuana (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "synthetic marijuana" (like "K2," "Spice")?	0	1	2+	
55c	During the **past 12 months**, on how many days did you use anything else to get high (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)?	0	1	2+	
56	Have you ever ridden in a **car** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Unsure	Yes	
57	Did your parent or anyone you **ever** lived with have a problem with drugs **OR** alcohol?	No	Unsure	Yes	
58	Do you ever forget to wear a seat belt?	No	Unsure	Yes	2 Safety
59	Do you ever forget to wear a helmet when on roller blades, a bike, skateboard, scooter, or motorcycle?	No	Do not ride	Yes	
60	Do you spend time near a swimming pool, river, lake, or hot tub?	No	Unsure	Yes	
61	Have you **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No	Unsure	Yes	
62	Did you **ever** live with anyone who physically hurt you in anger?	No	Unsure	Yes	
63	Have you **ever** been bullied or cyber bullied, or felt unsafe at school or in your neighborhood?	No	Unsure	Yes	
64	In the **past year**, have you been afraid of someone you were dating or had sex with?	No	Unsure	Yes	

If you have additional concerns, comments, or questions, please describe here:

Clinic Use Only: *circle each question with a positive response, sum number of circled questions*		
Child-ACE Exposures: 9 or 39 or 40 10 11 41 or 42 12 or 49 13 or 52 14 or 57 17 or 61 18 or 62 19		∑ =
Child-ACE Risks: 1 or 21		∑ =
Child-ACE Total		∑ =
PCP's Signature	Print Name	Date