

**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	<input type="checkbox"/> Biological Parent(s) <input type="checkbox"/> Step Parent(s) <input type="checkbox"/> Adopted Parent(s) <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Friend(s) <input type="checkbox"/> 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	No		Unsure			Yes				
	• Been seen in another clinic?	No		Unsure			Yes				
	• Developed a new illness?	No		Unsure			Yes				
	• Been seen in the Emergency Room?	No		Unsure			Yes				
	• Been hospitalized?	No		Unsure			Yes				
4	Since the last visit, has your child	No		Unsure			Yes				
	• Had an operation?	No		Unsure			Yes				
4	Do you have any questions or concerns about your child's growth or behavior? <i>If yes, please describe:</i>	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				

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:

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	<input type="checkbox"/> Self	If patient unable to complete, who helped fill out forms? <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Other (<i>specify</i>)			
	Do you live with...?	<input type="checkbox"/> Biological Parent(s) <input type="checkbox"/> Friend(s)	<input type="checkbox"/> Step Parent(s) <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Adopted Parent(s)	<input type="checkbox"/> Foster Parent(s)	
22	Do you have any questions or concerns about your growth or development? <i>If yes, please describe:</i>		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	<i>Girls only-</i> 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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for 12 – 17 Years CHILD FORM**

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?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Don't know (not sure) <input type="checkbox"/> Prefer not to answer				
46	What is your current gender identity?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> Other (another gender) <input type="checkbox"/> Transgender female <input type="checkbox"/> Transgender male <input type="checkbox"/> Don't know (not sure) <input type="checkbox"/> Prefer not to answer				
47	Do you think of yourself as...?	<input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Straight (heterosexual) <input type="checkbox"/> Bisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Asexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know (not sure) <input type="checkbox"/> 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? A1. Little interest or pleasure in doing things A2. Feeling down, depressed, or hopeless B1. Feeling nervous, anxious, or on edge B2. Not being able to stop or control worrying	Not at all	Several days	More than half the days	Nearly every day	4 Mental Health A: 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		

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	$\Sigma =$
		13 or 52	14 or 57	17 or 61	18 or 62	19	
Child-ACE Risks:		1 or 21					$\Sigma =$
Child-ACE Total							$\Sigma =$
PCP’s Signature			Print Name			Date	