Because your child’s physical as well as mental/emotional health are very important, please complete each of the following questions. We will have the opportunity to talk about some of these issues during your visit. Please indicate which items are most important to talk about today by placing a check mark in front of those items.

1. What worries or concerns you most about your child’s emotions and/or behaviors at this time?

2. Have there been changes in your family in the past year, such as marital separation, remarriage, move, family illness or death? If yes, what: No Yes

3. Are you afraid of anyone in your home? If yes, who: No Yes

4. Do you ever feel so frustrated that you may hit or hurt your child? No Yes

5. On a scale of 0 (Not at all) to 10 (a lot), how stressed is your child on a day-to-day basis? ______

6. Have you been worried about your child being angry, irritable, sad, fearful, or having a change in behavior in the last month? If yes, what is worrying you: No Yes

7. Do you have any worries about your child being sad? No Yes

8. Are you concerned about your child’s weight? If yes, what concerns you: No Yes

9. Who usually watches your child when you are not with him or her?

10. What is the easiest part about being your child’s parent?

11. What is the hardest part about being your child’s parent?

12. What worries you most about your child?

13. On a scale of 0 (Not at all) to 10 (a lot), how stressed are you on a day-to-day basis? ______

14. On a scale of 0 (Not at all) to 10 (a lot), how depressed are you from day-to-day? ______

15. How do you discipline your child?

16. Do you think that the way that you discipline your child is effective? No Yes

17. Do you think that your child has ever been abused? If Yes, when: No Yes
18. Has your child ever been through a traumatic or very frightening experience (for example, a motor vehicle accident, hospitalization, death of a loved one, watching arguments)?
   If Yes, when and what was the trauma?    No  Yes

19. Has your child ever been diagnosed with an emotional, behavioral, or mental health problem? If yes, what and when:    No  Yes

20. Has your child ever been on medication for an emotional, behavioral, or mental health problem? If yes, what medication and when:    No  Yes

21. Do you have guns in your home?    No  Yes

22. Are there stressful things that your family has been dealing with recently? If yes, what?    No  Yes

23. On a scale of 0 (Not at all) to 10 (very), how emotionally connected do you feel with your child?    ________

24. On a scale of 0 (very easy) to 10 (very difficult), how is your child’s temperament?    ________

25. Does your child have difficulty sleeping? If yes, what specifically (for example, difficulty falling asleep; waking up with nightmares):    No  Yes

26. Does anyone in your home smoke? If yes, who:    No  Yes

27. Does anyone in your home use alcohol or drugs to the point that you wish they would stop?    No  Yes

28. On a scale of 0 (None) to 10 (a lot), how much arguing goes on in your home?    ________

29. On a scale of 0 (Not at all) to 10 (a lot), do you overprotect your child?    ________

30. On a scale of 0 (Not at all) to 10 (very much so), how satisfied are you with being a parent to your child?    ________

31. On a scale of 0 (Not at all) to 10 (very much so), how consistent are you in setting limits with your child?    ________

32. Have you or any other of your child’s blood relatives ever been diagnosed with a mental health disorder? If yes, who and what:    No  Yes

This questionnaire may be photocopied (but not altered) and distributed to families. From A Practical Guide to Child and Adolescent Mental Health Screening, Early Intervention, and Health Promotion, Second edition. © 2013, National Association of Pediatric Nurse Practitioners, New York, NY.