

Grade

- K - Kindergarten
- 1 - First
- 2 - Second
- 3 - Third
- 4 - Fourth
- 5 - Fifth
- 6 - Sixth
- 7 - Seventh
- 8 - Eighth
- 9 - Ninth
- 10 - Tenth
- 11 - Eleventh
- 12 - Twelfth

Are you Hispanic or Latino/a?

- Yes
- No

What is your race? (Check all that apply)

- American Indian or Alaskan Native
- Black or African American
- White
- Asian
- Native Hawaiian or Other Pacific Islander

When you were born, what sex was put on your birth certificate?

- Male
- Female

Which of the following best describes you? (Check all that apply)

- Male
- Female
- Transgender
- Self-Identify

Which of the following best describes you?

- Heterosexual (Straight)
- Gay or Lesbian
- Bisexual
- Not Sure
- Not Listed

Was the patient's parent present while this questionnaire was completed?

- Yes
- No

Are you happy at school?

- Yes
- Sometimes
- No

Why not?

Do you like your teacher(s)?

- Yes
- Sometimes
- No

Do you have friends at school?

- Yes
- Sometimes
- No

Do you ever get in trouble at school?

- Yes
- Sometimes
- No

Is anyone ever mean to you or pick on you?

- Yes
- Sometimes
- No

What are you really good at? (Check All That Apply)

- Sports
- Art
- Music
- Dancing
- Video games
- I'm not good at anything
- Other

Other:

Where do you live?

- In a house
- In an apartment
- In a motel/hotel
- In a shelter
- In a group home
- In a foster home
- I move from place to place

Who lives with you? (Check All That Apply)

- Mom
- Dad
- Guardian
- Stepmom
- Stepdad
- Grandparent(s)
- Friend/roommate
- Brother/Sister
- At least one other family besides mine
- Aunt
- Uncle
- No one but me
- Foster parent
- Other

Other:

Who takes care of you when you are not at school? (Check All That Apply) The complete child version of the survey

- Mom/Dad
- Brother/Sister
- Grandparent(s)
- Aunt/Uncle
- Cousins
- Friend
- Neighbor
- No one – I take care of myself
- Other adult

Who do you talk to if you're feeling scared or sad? (Check All That Apply)

- Mom/Dad
- Brother/Sister
- Grandparent(s)
- Aunt/Uncle
- Cousins
- Friend
- Online friend
- Neighbor
- Teacher
- No one
- Other relative
- Other adult

Who are your favorite grown-ups? (Check All That Apply)

- Mom/Dad
- Brother/Sister
- Grandparent(s)
- Aunt/Uncle
- Cousins
- Online friend
- Neighbor
- Teacher
- No one
- Other relative
- Other adult

Does anyone sleep in your bed with you?

- Yes
- Sometimes
- No

Who sleeps in your bed with you? (Check All That Apply)

- Mom/Dad
- Brother/Sister
- Grandparent(s)
- Aunt/Uncle
- Cousins
- Friend
- Pets
- Other relative
- Other adult

For each statement, please tell me whether the statement was Often True, Sometimes True or Never True based on your experiences in the past 12 months:

I worried about not having enough to eat.

- Often True
- Sometimes True
- Never True

I tried not to eat a lot so that our food would last.

- Often True
- Sometimes True
- Never True

What activities do you do after school? (Check All That Apply)

- Play outside
- Play sports
- Play with my toys
- Play video games
- Art or music
- Go to a club
- Read
- Watch TV
- Spend time with friends
- Spend time with family
- Take care of brother, sister, other family
- Do homework
- Chores
- Other

Other:

What do you do on weekends? (Check All That Apply)

- Play outside
- Play sports
- Play with my toys
- Play video games
- Art or music
- Go to a club
- Read
- Watch TV
- Spend time with friends
- Spend time with family
- Take care of brother, sister, other family
- Do homework
- Chores
- Other

Other:

Do you have a coat that keeps you warm?

- Yes
- Sometimes
- No

Do you have shoes that fit?

- Yes
- Sometimes
- No

Does anyone in your house smoke or vape?

- Yes
- Sometimes
- No

Have you ever smoked or vaped?

- Yes
- Sometimes
- No

Do you always wear a seatbelt when driving or riding in a car, truck or van?

- Yes
- No

Do you feel safe playing outside?

- Yes
- Sometimes
- No

Who do you play with? (Check All That Apply)

- Friend
- Mom/Dad
- Pets
- Brother/Sister
- Cousins
- Neighbor
- By myself
- Other adult

Is there a gun in your home?

- Yes
- Sometimes
- No

Have your parents talked to you about being safe with guns ?

- Yes
- No

Do you feel unsafe when you get in trouble at home?

- Yes
- Sometimes
- No

Please describe:

In the last 6 months, have you seen a dentist or gone to a dental clinic?

- Yes
- No

Do you have any tooth pain right now?

- Yes
- No

Are there any questions you want to ask me?

Do you have any questions about ways your body might be changing?

What do you want to be when you grow up?

Provider Actions: (check all that apply)

- No concerns
- Addressed home/school concerns
- Counseled on health behaviors
- Safety concerns addressed
- Referred for medical care
- Already in therapy
- In-house therapy provided
- Recommended therapy but refused
- Follow-up scheduled for concerns

Comments:

What type of provider signature would you like to add? (if a box is already checked, leave it checked so both signatures will appear)

Primary Care

Behavioral Health

Sign Here

Signature Date

Behavioral Health Signature

Behavioral Health Signature Date