Pediatric Professional Associates

Parent Questionnaire

Date: _____

Patient Name: _____ **DOB**: _____

Are your child's parents: □ *Married* □ *Unmarried* □ *Separated* □ *Divorced* □ *Widowed*

Date of Separation/Divorce: _____

Concerns about your child (please check all that apply):

□ *Alcohol/Drug Use*

□ *Tobacco*

□ *Sexual Activity*

□ *Behaviors*

□ *Mood/Emotions*

□ *learning ability*

□ *body is growing*

□ *getting along with others*

Is violence at home a concern? □ *Yes* □ *No*

Are there pets in the home? □*Yes* □ *No*

Are there guns in the home? □*Yes* □ *No* *If yes, are they locked and stored safely?* □ *Yes* □ *No*

Do any family members smoke? □*Yes* □ *No*

Any concerns regarding how much/ what kinds of foods is your child eating? □ *Yes* □ *No*

Any concerns regarding how much sleep your child is getting nightly? □ *Yes* □ *No*

Are there any problems in your home that might affect your child? □ *Yes* □ *No*

Are there any issues that make it hard for you to provide for your child's health? □ *Yes* □ *No*

Does your child spend more than 2 hours per day of TV/computer/electronic time? □ *Yes* □ *No*