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[www.generationsprimarycare.com](http://www.generationsprimarycare.com)

Dear Parents of a 11 to 14 year old child:

Many changes occur for your child in the transition from Late Childhood into Early and Late Adolescence. Children transition through these phases at very different ages. The following questionnaires help to guide us in identifying health risks and behaviors that may affect your child's health.

The included child's questionnaire asks only very superficial questions about substance abuse and sexual activity. If you have concerns that your child may be experimenting in these areas already, please let our staff know so that we may provide a more comprehensive set of questions.

Please respect your child's privacy as they fill out these questions. We will not share the answers they provide without their permission unless there are signs of an immediate danger to their health. Confidentiality helps your child provide honest answers and helps us to address any issues before they can cause permanent injury. Most children will eventually allow open discussion with their parents after we have worked through the initial concerns together.

Sincerely,

The Providers of Generations Primary Care



# Bright Futures Parent Supplemental Questionnaire Older Child/Early Adolescent Visits

Your Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Your Child's Age \_\_\_\_\_ Your Child's Sex (circle one): M F \_\_\_\_\_ Your Child's Grade (in school) \_\_\_\_\_

## Your Growing and Changing Child: Physical Growth and Development

1.	Does your child live in your home?	Yes	Sometimes	No
2.	Does your child receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
3.	Does your child brush his teeth twice a day?	Yes		No
4.	Does your child floss once a day?	Yes		No
5.	Has your child seen a dentist in the past year?	Yes		No
6.	Does your child eat 5 or more helpings of fruits and vegetables each day?	Yes		No
7.	Does your child drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes		No
8.	Does your child eat more than 1 fast food meal per week?	No	Sometimes	Yes
9.	Does your child do any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	Yes		No
10.	Does your child drink more than 1 soda or juice drink each day?	No		Yes
11.	Does your child watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
12.	Does your child have a problem with weight (such as underweight, overweight, anorexia, or bulimia)?	No		Yes
13.	Do you eat meals together as a family?	Yes		No
14.	Have you and your child discussed the physical and emotional changes that happen during puberty?	Yes		No
15.	Does your child have a TV in his bedroom?	No		Yes
16.	Have you talked to your child about waiting to have sex?	Yes		No
17.	For your daughter: Have she gotten her period?	Yes		No
18.	If yes, is she having any problems with or does she have any questions about her period?	No	Sometimes	Yes



### School and Friends: Social and Academic Competence

19.	Does your child go to school?	Yes		No
20.	Is your child having any problems in school? Circle all that apply: grades worse than last year failing grades homework suspension this year fighting missing school other _____	No	Sometimes	Yes
21.	Is doing well in school important to you and your child?	Yes		No
22.	Do you know your child's friends and their families?	Yes		No
23.	Do you help your child see things from another person's point of view?	Yes		No
24.	Do you encourage your child to think through solutions rather than giving her the answers?	Yes		No

### Violence and Injuries: Violence and Injury Prevention

25.	Does your child always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
26.	Does your child have access to a gun at home or in places where she spends time?	No	Sometimes	Yes
27.	Does your child wear a helmet when he in-line skates, skateboards, bicycles, skis, or snowboards?	Yes	Sometimes	No
28.	Has your child had someone at home, school, or anywhere else who made her feel afraid, threatened her, or hurt her?	No		Yes
29.	Does your child wear protective gear when playing team sports?	No		Yes

### Feeling Happy: Emotional Well-being

30.	Even with usual ups and downs, do you feel your child enjoys life?	Yes		No
31.	Do you praise your child when he does something good or learns something new?	Yes		No
32.	Do you spend time talking with your child every day?	Yes		No
33.	Do you clearly discuss with your child rules and family rules?	Yes		No
34.	Does your child worry a lot or feel overly stressed out?	No	Sometimes	Yes
35.	When your child is angry, does he do violent things?	No		Yes
36.	Does your child continue to remember, think, or talk about an unpleasant experience that happend in the past?	No		Yes

*continued on page 3*



**Feeling Happy: Emotional Well-being** *continued from page 2*

37.	During the past few weeks has your child often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though he has nothing to look forward to?	No		Yes
38.	Do you talk with your child about relationships and sex?	Yes		No
39.	Do you talk with your child about alcohol and drugs?	Yes		No
40.	Has your child ever seriously thought about killing himself, made a plan, or tried to kill himself?	No		Yes

**Healthy Behavior Choices: Risk Reduction**

41.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	No	Sometimes	Yes
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# Bright Futures Medical Screening Questionnaire Older Child/Younger Adolescent Visits

## For Parents

Please answer the following questions by circling Y, N, or Unsure.

Does your child complain that the blackboard has become difficult to see?	Y	N	Unsure
Has your child ever failed a school vision screening test?	Y	N	Unsure
Does your child hold books close to read?	Y	N	Unsure
Does your child have trouble recognizing faces at a distance?	Y	N	Unsure
Does your child tend to squint?	Y	N	Unsure
Does your child have a problem hearing over the telephone?	Y	N	Unsure
Does your child have trouble following the conversation when 2 or more people are talking at the same time?	Y	N	Unsure
Does your child have trouble hearing with a noisy background?	Y	N	Unsure
Does your child ask people to repeat themselves?	Y	N	Unsure
Does your child misunderstand what others are saying and respond inappropriately?	Y	N	Unsure
Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure
Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	Y	N	Unsure
Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	Y	N	Unsure
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure
Has your child ever been diagnosed with iron deficiency anemia?	Y	N	Unsure

## FOR FEMALES ONLY

Does your child have excessive menstrual bleeding or other blood loss?	Y	N	Unsure
Does your child's period last more than 5 days?	Y	N	Unsure



# Bright Futures Parent Handout Early Adolescent Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

## Your Growing and Changing Child

- Talk with your child about how her body is changing with puberty.
- Encourage your child to brush his teeth twice a day and floss once a day.
- Help your child get to the dentist twice a year.
- Serve healthy food and eat together as a family often.
- Encourage your child to get 1 hour of vigorous physical activity every day.
- Help your child limit screen time (TV, video games, or computer) to 2 hours a day, not including homework time.
- Praise your child when she does something well, not just when she looks good.

PHYSICAL GROWTH AND DEVELOPMENT

## Healthy Behavior Choices

- Help your child find fun, safe things to do.
- Make sure your child knows how you feel about alcohol and drug use.
- Consider a plan to make sure your child or his friends cannot get alcohol or prescription drugs in your home.
- Talk about relationships, sex, and values.
- Encourage your child not to have sex.
- If you are uncomfortable talking about puberty or sexual pressures with your child, please ask me or others you trust for reliable information that can help you.
- Use clear and consistent rules and discipline with your child.
- Be a role model for healthy behavior choices.

RISK REDUCTION

## Feeling Happy

- Encourage your child to think through problems herself with your support.
- Help your child figure out healthy ways to deal with stress.
- Spend time with your child.
- Know your child's friends and their parents, where your child is, and what he is doing at all times.
- Show your child how to use talk to share feelings and handle disputes.
- If you are concerned that your child is sad, depressed, nervous, irritable, hopeless, or angry, talk with me.

EMOTIONAL WELL-BEING

## School and Friends

- Check in with your child's teacher about her grades on tests and attend back-to-school events and parent-teacher conferences if possible.
- Talk with your child as she takes over responsibility for schoolwork.
- Help your child with organizing time, if he needs it.
- Encourage reading.
- Help your child find activities she is really interested in, besides schoolwork.
- Help your child find and try activities that help others.
- Give your child the chance to make more of his own decisions as he grows older.

SOCIAL AND ACADEMIC COMPETENCE

## Violence and Injuries

- Make sure everyone always wears a seat belt in the car.
- Do not allow your child to ride ATVs.
- Make sure your child knows how to get help if he is feeling unsafe.
- Remove guns from your home. If you must keep a gun in your home, make sure it is unloaded and locked with ammunition locked in a separate place.
- Help your child figure out nonviolent ways to handle anger or fear.

VIOLENCE AND INJURY PREVENTION

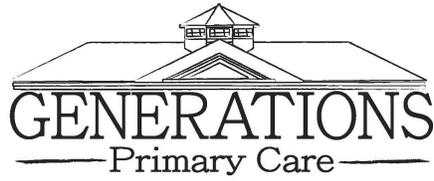


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Dear Patient:

The following forms are provided so that you can help us have a more complete picture of your health. Some of these questions ask very personal information. These questionnaires will remain private unless you grant us permission to share them with your family. Please answer them honestly and to the best of your ability. If there are questions that you are not sure how to answer, we can review them together later during your office visit.

Sincerely,

The Providers of Generations Primary Care



# Bright Futures Adolescent Supplemental Questionnaire—Older Child/Younger Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Your Age \_\_\_\_\_ Your Sex (circle one): M F \_\_\_\_\_ Your Grade (in school) \_\_\_\_\_

## Your Growing and Changing Body: Physical Growth and Development

1.	Do you live in your parents' home?	Yes	Sometimes	No
2.	Do you receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
3.	Do you brush your teeth twice a day?	Yes		No
4.	Do you floss once a day?	Yes		No
5.	Have you seen a dentist in the past year?	Yes		No
6.	Do you eat 5 or more helpings of fruits and vegetables each day?	Yes		No
7.	Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes		No
8.	Do you eat more than 1 fast food meal per week?	No	Sometimes	Yes
9.	Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	Yes		No
10.	Do you drink more than 1 soda or juice drink each day?	No		Yes
11.	Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
12.	Do you have any concerns or questions about the size or shape of your body, or physical appearance?	No		Yes
13.	Do you have a problem with your weight (such as underweight, overweight, anorexia, or bulimia)?	No		Yes
14.	Are you on a diet to lose weight?	No		Yes
15.	Do you eat meals together as a family?	Yes		No
16.	Have you talked about body changes and puberty with your parents?	Yes		No
17.	Do you have a TV in your bedroom?	No		Yes
18.	Have you talked to your parents about waiting to have sex?	Yes		No
19.	For females: Have you gotten your period?	Yes		No
20.	If yes, are you having any problems with or do you have any questions about your period?	No	Sometimes	Yes



### School and Friends: Social and Academic Competence

21.	Do you go to school?	Yes		No
22.	Are you having any problems in school? Circle all that apply:    grades worse than last year    failing grade    homework suspension this year    fighting    missing school    other _____	No	Sometimes	Yes
23.	Is doing well in school important to you?	Yes		No
24.	Do your parents know your friends and their families?	Yes		No
25.	Do you try to see things from another person's point of view?	Yes		No
26.	Do you try to think through solutions by yourself?	Yes		No

### Violence and Injuries: Violence and Injury Prevention

27.	Do you always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
28.	Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time?	No	Sometimes	Yes
29.	Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	Yes	Sometimes	No
30.	Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	No		Yes
31.	Do you have a person you can call for a ride if you're feeling unsafe with someone?	Yes		No

### How You Are Feeling: Emotional Well-being

32.	Even with usual ups and downs, do you feel you enjoy life?	Yes		No
33.	Do your parents praise you when you do something good or learn something new?	Yes		No
34.	Do you spend time talking with your parents every day?	Yes		No
35.	Do you clearly discuss with your parents their rules and how you should act?	Yes		No
36.	Do you worry a lot or feel overly stressed out?	No	Sometimes	Yes
37.	When you are angry, do you do violent things?	No		Yes
38.	Do you continue to remember or think about an unpleasant experience that happened in the past?	No		Yes

*continued on page 3*



**Feeling Happy: Emotional Well-being** *continued from page 2*

39.	Do you do things as a family?	Yes		No
40.	During the past few weeks have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you have nothing to look forward to?	No		Yes
41.	Do you talk with your parents about relationships and sex?	Yes		No
42.	Do you talk with your parents about alcohol and drugs?	Yes		No
43.	Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?	No		Yes

**Healthy Behavior Choices: Risk Reduction**

44.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	No	Sometimes	Yes
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## For Patients

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

Please answer the following questions by circling Y, N, or Unsure.

Do you smoke cigarettes?	Y	N	Unsure
Have you ever had an alcoholic drink?	Y	N	Unsure
Have you ever used marijuana or any other drug to get high?	Y	N	Unsure
Have you ever been diagnosed with iron deficiency anemia?	Y	N	Unsure
Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure
<b>FOR FEMALES ONLY</b>			
Does your period last more than 5 days?	Y	N	Unsure
Do you have excessive menstrual bleeding or other blood loss?	Y	N	Unsure



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# Bright Futures Patient Handout

## Early Adolescent Visits

### Your Growing and Changing Body

- Brush your teeth twice a day and floss once a day.
- Visit the dentist twice a year.
- Wear your mouth guard when playing sports.
- Eat 3 healthy meals a day.
- Eating breakfast is very important.
- Consider choosing water instead of soda.
- Limit high-fat foods and drinks such as candy, chips, and soft drinks.
- Try to eat healthy foods.
  - 5 fruits and vegetables a day
  - 3 cups of low-fat milk, yogurt, or cheese
- Eat with your family often.
- Aim for 1 hour of moderately vigorous physical activity every day.
- Try to limit watching TV, playing video games, or playing on the computer to 2 hours a day (outside of homework time).
- Be proud of yourself when you do something good.

PHYSICAL GROWTH AND DEVELOPMENT

RISK REDUCTION

### Healthy Behavior Choices

- Find fun, safe things to do.
- Talk to your parents about alcohol and drug use.
- Support friends who choose not to use tobacco, alcohol, drugs, steroids, or diet pills.
- Talk about relationships, sex, and values with your parents.
- Talk about puberty and sexual pressures with someone you trust.
- Follow your family's rules.

### How You Are Feeling

- Figure out healthy ways to deal with stress.
- Spend time with your family.
- Always talk through problems and never use violence.
- Look for ways to help out at home.
- It's important for you to have accurate information about sexuality, your physical development, and your sexual feelings. Please consider asking me if you have any questions.

EMOTIONAL WELL-BEING

### School and Friends

- Try your best to be responsible for your schoolwork.
- If you need help organizing your time, ask your parents or teachers.
- Read often.
- Find activities you are really interested in, such as sports or theater.
- Find activities that help others.
- Spend time with your family and help at home.
- Stay connected with your parents.

SOCIAL AND ACADEMIC COMPETENCE

### Violence and Injuries

- Always wear your seatbelt.
- Do not ride ATVs.
- Wear protective gear including helmets for playing sports, biking, skating, and skateboarding.
- Make sure you know how to get help if you are feeling unsafe.
- Never have a gun in the home. If necessary, store it unloaded and locked with the ammunition locked separately from the gun.
- Figure out nonviolent ways to handle anger or fear. Fighting and carrying weapons can be dangerous. You can talk to me about how to avoid these situations.
- Healthy dating relationships are built on respect, concern, and doing things both of you like to do.

VIOLENCE AND INJURY PREVENTION



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