



Pediatric Comprehensive Health Questionnaire

Demographic Information

Male Female

First Name: _____ Middle Initial: _____ Last Name: _____

Age: _____ Date of Birth: _____ Height: ' " Weight: _____

Ethnicity: Native American Asian African American Hispanic/Latino
 Native Hawaiian/Pacific Islander Caucasian Other Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _____

Relationship: _____ Referral Source: _____

Contact Information

Address: _____

City: _____ State/Prov: _____ Zip/PC: _____

Email: _____ Home/Cell: _____

Parent Employer: _____ Work Phone: _____

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State/Prov: _____ Zip/PC: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State/Prov: _____ Zip/PC: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State/Prov: _____ Zip/PC: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all examination findings and diagnosis, report, and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Parent/Guardian Signature: _____

Date: _____

What is your chief concern and reason for this visit?

Does your child currently experience any of the following symptoms?

Indicate all that apply and number your top chief complaints 1-4

Sleep Conditions

Regular bedtime	<input type="checkbox"/> Yes <input type="checkbox"/> No	Resist going to bed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty falling asleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	Awakenings from sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty awakening in AM	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor sleeper	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Restless sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sweating when sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Daytime sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nightmares	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep talking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep terrors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg kicking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting out of bed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Teeth grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gasping during sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Daytime sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Naps after school	<input type="checkbox"/> Yes <input type="checkbox"/> No	Falls asleep at school	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____			

Pain Conditions

Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Noises in jaw joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty opening mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Growing pains	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other _____			

Other Conditions

Nasal congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty breathing through nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent colds or flu	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Throat infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid reflux (GERD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Delayed growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fussy eater	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive weight	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tubes in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chromosomal disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tooth crowding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Delayed tooth eruption	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tongue-tie	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drooling while eating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Developmental delay	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperactivity ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety/Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Learning disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsils removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adenoids removed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tubes in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue-tie release	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tooth extractions	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other _____			

What are the results you are seeking from treatment?

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Metals | <input type="checkbox"/> Plastics |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Food Allergies/Sensitivities | | Other: _____ |

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason for Taking

See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (Y/N)

See attached list

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Does any family member have a sleep breathing disorder? Yes No If yes, explain:

Has your child had any of the following:

- | | | |
|--|---|-----------------------|
| Orthodontic Treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Stopped breathing during sleep? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sleep Study? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> HST (Home Sleep Test) <input type="checkbox"/> PSG (Polysomnogram in Sleep Lab) | Date: _____ | Result: _____ |
| Positive Airway Pressure Devices Used? | <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> ASV <input type="checkbox"/> APAP | |
| Orthodontic Appliance? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Myofunctional Therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Other Therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Breastfed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Until what age? _____ |
| Bottle fed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Until what age? _____ |
| Pacifier | <input type="checkbox"/> Yes <input type="checkbox"/> No | Until what age? _____ |
| Thumb or Finger Habit | <input type="checkbox"/> Yes <input type="checkbox"/> No | Until what age? _____ |
| Other: _____ | | |

Medical History - Patient and Family

Do you have or have experienced any of the following?

	PATIENT HX	FAMILY HX	I HAVE NO FAMILY HX	PATIENT HX	FAMILY HX
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Awakenings from Sleep	<input checked="" type="checkbox"/>	x	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Bleeding Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birth Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bruising Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer of _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Hands and Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Concentrating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Breathing at Night	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(EDS) Ehlers-Danlos Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive Thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fluid Retention	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Colds/Flu	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Ear Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastroesophageal Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Valve Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Huntington's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Fam Hx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<hr/>					
I HAVE NO FAMILY HX					
<p>- Hypoglycemia</p> <p>Insomnia</p> <p>Intestinal Disorder</p> <p>Irregular Heartbeat</p> <p>Kidney Disease</p> <p>Leukemia</p> <p>Liver Disease</p> <p>Low Blood Pressure</p> <p>Meniere's Disease</p> <p>Memory Loss</p> <p>Migraines</p> <p>Mitral Valve Prolapse</p> <p>Multiple Sclerosis</p> <p>Muscle Aches</p> <p>Muscle Fatigue</p> <p>Muscle Spasms</p> <p>Muscular Dystrophy</p> <p>Neuralgia</p> <p>Nervous system Disorder</p> <p>Osteoarthritis</p> <p>Osteoporosis</p> <p>Ovarian Cyst</p> <p>Parkinson's Disease</p> <p>Poor Circulation</p> <p>(POTS) Postural Orthostatic Tachycardia Syndrome</p> <p>Psychiatric Care</p> <p>Radiation</p> <p>Recent Weight Gain</p> <p>Recent Weight Loss</p> <p>Rheumatic Fever</p> <p>Rheumatoid Arthritis</p> <p>Scarlet Fever</p> <p>Shortness of Breath</p> <p>Skin Disorder</p> <p>Sinus Problems</p> <p>Slow Healing Sores</p> <p>Speech Difficulties</p> <p>Stroke</p> <p>Swollen or Painful Joints</p> <p>Thyroid Disease</p> <p>Tired Muscles</p> <p>Tuberculosis</p> <p>Urinary Tract Disorder</p> <p>OTHER _____</p>					
<hr/>					

BEARS SLEEP SCREENING

The “BEARS” instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate “trigger questions” for use in the clinical interview.

B = bedtime problems

E = excessive daytime sleepiness

A = awakenings during the night

R = regularity and duration of sleep

S = snoring

The parent answers questions in **black**, the subject child answers questions written in **blue**:

Symptom	Age Toddler/Preschool (2-5 years)	Age School Age (6-12 years)	Age Adolescent (13-18 years)
1. Bedtime Problems	Does your child have any problems going to bed? (P) Yes No	Does your child have any problems at bedtime? (P) Yes No Do you have any problems going to bed? (C) Yes No	Do you have any problems falling asleep at bedtime? (C) Yes No
2. Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day? (P) Yes No	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Yes No Do you feel tired a lot? (C) Yes No	Do you feel sleepy a lot during the day? (C) Yes No Do you feel sleepy a lot in School? (C) Yes No Do you feel sleepy a lot while Driving? (C) Yes No
3. Awakenings during the night	Does your child wake up a lot at night? (P) Yes No	Does your child seem to wake up a lot at night? (P) Yes No Any sleepwalking or nightmares? (P) Yes No Do you wake up a lot at night? (C) Yes No Have trouble getting back to sleep? (C) Yes No	Do you wake up a lot at night? (C) Yes No Have trouble getting back to sleep? (C) Yes No
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? (P) Yes No What are they? Bedtime Wake Time	What time does your child go to bed and get up on school days? Bedtime Wake Time Weekends? Bedtime Wake Time Do you think he/she is getting enough sleep? (P) Yes No	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get? (C)
5. Snoring	Does your child snore a lot or have difficulty breathing at night? (P) Yes No	Does your child have loud or nightly snoring or any breathing difficulties at night? (P) Yes No	Does your teenager snore loudly or nightly? (P) Yes No

(P) Parent-directed question

(C) Child-directed question

Source: “A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems” by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins

PEDIATRIC SLEEP QUESTIONNAIRE (PSQ)

1. While sleeping does your child....

- | | | |
|--|------------------------------|-----------------------------|
| Snore more than half the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Always snore? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Snore loudly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have "heavy" or loud breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have trouble breathing or struggle to breathe | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seen your child stop breathing during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. Does your child....

- | | | |
|---|------------------------------|-----------------------------|
| Tend to breathe through the mouth during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have a dry mouth on waking up in the morning? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Occasionally wet the bed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wake up feeling unrefreshed in the morning? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have a problem with sleepiness during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have a teacher or other supervisor comment that your child appears sleepy during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Find it hard to wake your child up in the morning? | Yes | No |
| Wake up with headaches in the morning? | Yes | No |

3. Did your child stop growing at a normal rate at any time since birth?

Yes No

4. Is your child overweight?

Yes No

5. This child often....

- | | | |
|--|------------------------------|-----------------------------|
| Does not seem to listen when spoken to directly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has difficulty organizing tasks and activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is easily distracted by extraneous stimuli? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fidgets with hands or feet or squirms in seat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is "on the go" or often acts as if "driven by a motor"? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Interrupts or intrudes on others (butts into conversations or games) ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Severity Measure for Depression—Child Aged 11-17*

**PHQ-9 modified for Adolescents (PHQ-A)—Adapted*

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an “X” in the box that best describes how you have been feeling.

	Not at all (0)	Several days (1)	More than Half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, irritable, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling/staying asleep, sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite, weight loss or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself or that you are a failure or have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as Schoolwork, reading or watching TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead Or of hurting yourself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Column Totals _____x0 + _____x1 + _____x2 + _____x3

Total /Partial Raw Score _____

Generalized Anxiety Disorder (GAD-7) Questionnaire

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all (0)	Several days (1)	More than Half the days (2)	Nearly every day (3)
Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid, as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Column Totals _____x0 + _____x1 + _____x2 + _____x3

Total Score _____

If you checked off any problem on the questionnaire so far, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

not difficult at all somewhat difficult very difficult extremely difficult

Parent/Guardian Signature: _____ Date: _____