PHQ9P

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (US Spanish version of the PHQ)

72883

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias por cualquiera de las siguientes dificultades?	No del todo	Varios días	Más de la mitad de los días	Casi todos los días
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Sintiéndose decaído(a), deprimido(a), o sin esperanzas	0	1	2	3
3. Dificultad en caer o permanecer dormido(a), o dormir demasiado	0	1	2	3
4. Sintiéndose cansado o teniendo poca energia	0	1	2	3
5. Pobre de apetito o comer en exceso	0	1	2	3
6. Sintiéndose mal con usted mismo(a) – o que usted es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Dificultad en concentrarse en cosas, tales como leer el periódico o ver televisión	0	1	2	3
8. ¿Moviéndose o hablando tan lento, que otras personas podrían notarlo? O lo contrario – muy inquieto(a) o agitado(a) que usted ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que usted estaria mejor muerto(a) o de alguna manera lastimándose a usted mismo(a)	0	1	2	3

SCORING FOR USE BY STUDY PERSONNEL ONLY

0 + ______ + ______ + ______

=Total Score: ______

Si usted marcó cualquiera de los problemas, ¿qué tan difícil han afectado estos problemas en hacer su trabajo, encargarse de tareas del hogar, o llevarse bien con otras personas?

Para nada difícil	Un poco difícil	Muy difícil	Extremadamente difícil
☐	☐	☐	☐

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Confirmo que la información en este formulario es correcta.	Iniciales del paciente:	Fecha:

______________ MRN ______________________ PROVEEDOR

VALORACION DE HABITOS SALUDABLES

Nombre del paciente ______________________

Fecha de nacimiento ______________ Fecha ______________

Encierre en un círculo la respuesta que mejor describa los hábitos de alimentación y de actividad física promedio de su niño.

Mi hijo consume verduras y frutas:

0-1 veces al día | 1-2 veces al día | 3-4 veces al día | Más de 4 veces al día

Mi hijo come fuera:

Más de 4 veces por semana | 3-4 veces por semana | 1-2 veces por semana | 0-1 veces por semana

Mi hijo es activo:

No muy a menudo | Menos de 30 minutos al día | 30-60 minutos al día | Más de 60 minutos al día

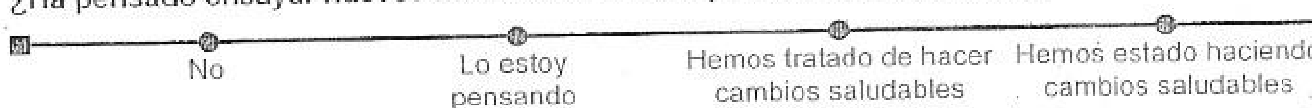
Mi hijo toma bebidas azucaradas (gaseosas, té dulce, jugos, bebidas deportivas, otras bebidas con jugo):

Más de 3 al día | 2 al día | 1 al día | No muy a menudo

Mi hijo ve televisión o pasa tiempo en la computadora o en juegos de video:

Más de 2 horas al día | 1-2 horas al día | 30-60 minutos al día | No muy a menudo durante el día

¿Ha pensado ensayar nuevos hábitos saludables para su hijo o su familia?



No | Lo estoy pensando | Hemos tratado de hacer cambios saludables | Hemos estado haciendo cambios saludables

Si pudiera hacer un solo cambio saludable, ¿Cuál sería?

- ❑ Llene la mitad del plato con frutas y verduras
- ❑ Limite el tiempo frente a la pantalla a una hora
- ❑ Mantenga actividad durante 60 minutos
- ❑ Tome más agua y limite las bebidas azucaradas

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Name: ____________________

11-14 years DOB: ____________________

Bright Futures Previsit Questionnaire
Early 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.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

____

____

What changes or challenges have there been at home since last year?

____

____

Do you live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ Teeth ☐ Appearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ How your body is changing ☐ Your weight
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable
Healthy Behavior Choices	☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Pregnancy ☐ Sexually transmitted infections (STIs) ☐ Decisions about sex and drugs
Violence and Injuries	☐ Car safety ☐ Using a helmet or protective gear ☐ Keeping yourself safe in a risky situation ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Have you ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Growing and Developing

Check off all of the items that you feel are true for you.

- ☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ☐ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ☐ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ☐ I am able to bounce back from life's disappointments.
- ☐ I have a sense of hopefulness and self-confidence.
- ☐ I have become more independent and made more of my own decisions as I have become older.
- ☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

____

____

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Bright Futures Previsit Questionnaire
Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

____

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What changes or challenges have there been at home since last year?

____

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Does your child have any special health care needs? ☐ No ☐ Yes, describe:

____

____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:

____

____

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? ____________

Questions About Your Child

Vision	Does your child complain that the blackboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Has your child ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Does your child hold books close to read?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Does your child tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Does your child have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Does your child ask people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Does your child misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	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)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your child's period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Your Growing and Developing Child

Check off all of the items that you feel are true for your child.

☐ My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe.
☐ My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
☐ My child has at least one friend or a group of friends with whom she is comfortable.
☐ My child helps others individually or by working with a group in school, a faith-based organization, or the community.
☐ My child is able to bounce back from life's disappointments.
☐ My child has a sense of hopefulness and self-confidence.
☐ My child has become more independent and made more of his own decisions as he has become older.
☐ My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

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