RISK QUESTIONNAIRE 10-12 YEARS OLD

NAME_______________________________________ DATE OF BIRTH____

MENTAL HEALTH QUESTIONNAIRE

Check all answers that may apply.
by the parent/guardian or health care provider

Does your child have trouble paying attention ☐ Yes ☐ No

Does your child often seem:
- Distrustful of others ………………………… ☐ Yes ☐ No
- To express strange thoughts ☐ Yes ☐No
- Blame others …………………………………………… ☐ Yes ☐ No

Does your child have problems at school with:
- Behavior ………………………………………………… ☐ Yes ☐ No
- Grades ……………………………………………… … ☐ Yes ☐ No
- Skipping classes ……………………………………… ☐ Yes ☐ No

Do you have concerns about your child's:
- Eating …………………………………………………… ☐ Yes ☐ No
- Sleep …………………………………………………… ☐ Yes ☐ No
- Weight ………………………………………………… ☐ Yes ☐ No

Does your child often complain of "not feeling well"? ……… ☐ Yes ☐ No

Does your child have trouble making or keeping friends? … ☐ Yes ☐ No

Does your child often seem:
- Sad ……………………………………………………… ☐ Yes ☐ No
- Angry …………………………………………………… ☐ Yes ☐ No
- Nervous or afraid …………………………………… ☐ Yes ☐ No

Does your child show any of these behavior:
- Destroy property ………………………………… ☐ Yes ☐ No
- Set fire ………………………………………………… ☐ Yes ☐ No
- Lie ……………………………………………………… ☐ Yes ☐ No
- Steal …………………………………………………… ☐ Yes ☐ No
- Listen to music with violent message ………… ☐ Yes ☐ No
- Hurt animal or smaller children ………………… ☐ Yes ☐ No
- Use alcohol ………………………………………… ☐ Yes ☐ No
- Use drugs …………………………………………… ☐ Yes ☐ No
- Smoke cigarettes ………………………………… ☐ Yes ☐
No
- Sexually active ☐ Yes ☐ No

Is there a history of injuries, accidents? ………… ☐ Yes ☐ No
If yes, please specify:
____

Is there any history of maltreatment or abuse? ……… ☐ Yes ☐ No
If yes, please specify:
____

Is there a recent stress on the family or child such as:
- Birth of a child ………………………… ☐ Yes ☐ No
- Moving …………………………………… ☐ Yes ☐ No
- Divorce or separation ……………… ☐ Yes ☐ No
- Death of a close relative ………… ☐ Yes ☐ No
- Fired or laid off ………………… ☐ Yes ☐ No
- Legal problems ………………………… ☐ Yes ☐ No
- Others (Please specify): ____________ ☐ Yes ☐ No

Do you have other parenting concerns? ☐ Yes ☐ No
Please specify:
____

STD/HIV RISK ASSESSMENT:

(12 years through 20 years)

1. Have you had a blood transfusion or are you a Hemophiliac? YES NO
2. Have you ever been sexually molested or physically attacked? YES NO
3. Have you ever been diagnosed with any sexually transmitted diseases? YES NO
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy? YES NO
5. If sexually active, have you had unprotected sex, with opposite/same sex? YES NO
6. If sexually active, have you had more than one partner? YES NO
7. Any body tattoos or body piercing of ears, navel, etc, including any performed by friends? YES NO

(A "yes" response to any question indicates a positive risk)

TUBERCULOSIS RISK ASSESSMENT

Starting at 1 year of age and annually thereafter)

1. Has your child been exposed to anyone with a case of TB? YES NO
2. Was your child, or a household member, born in an area where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)? YES NO
3. Has your child, or a household member, lived more than a year in an area where TB is common? YES NO
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? YES NO
5. Does your child have HIV infection? YES NO

(A "yes" response to any question indicates a positive risk)

Provider: Give details of Positive Mental Health findings:

Heart Disease/Cholesterol Risk Assessment:

(2 years through 20 years)

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death? YES NO
2. Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher) YES NO

(A "yes" response to either question 1 or 2 indicates a positive risk.) YES NO

3. Is the child/adolescent overweight? YES NO
4. And is there also a personal history of:
   - Smoking? YES NO
   - Lack of physical activity? YES NO
   - High blood pressure? YES NO
   - High cholesterol? YES NO
   - Diabetes mellitus? YES NO

(A "yes" response to both questions 3 and 4 indicates a positive risk)

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NAME____ DATE OF BIRTH____

Provider Signature__________________________ Date________________