

Child Name: _____

For Patients Age 12 & Up

PATIENT HEALTH QUESTIONNAIRE - 1

Note: This side is to be completed by the PATIENT

Over the last 2 weeks, how often have you been bothered
by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems 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
☐

*** CONTINUE TO BACK FOR IMPORTANT HEALTH AND SAFETY QUESTIONS ***



Child Name: _____

The questions below are to be answered by PARENT/LEGAL GUARDIAN.

HEALTH AND SAFETY

We are devoted to the health and safety of you and your family. Please tell us how comfortable you feel with the following necessities:

I have enough **MONEY** to provide for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am able to provide **FOOD** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am able to provide **HOUSING** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am able to provide or arrange **TRANSPORTATION** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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VISION and/or HEARING SCREENINGS

The American Academy of Pediatrics recommends vision and hearing screenings be done on various ages of children starting at age 3 years and above. If your child has not been tested by your school system, we can provide those services in our office.

I, _____ give my consent for my child
Parent's Name (printed)

_____, to have a vision and hearing screening performed by
Child's Name (printed)
Westerville Pediatric Specialists, Inc.

I **ACCEPT** the vision and/or hearing screening at this time for my child.

Date _____ Signature _____

I **DECLINE** the vision and/or hearing screening at this time for my child.

Date _____ Signature _____