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 ***

Westerville Pediatric Specialists, Inc.

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
☐	☐	☐	☐	☐

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

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

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

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

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

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

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 _____

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STI SCREENING

Becoming a young adult is exciting, difficult, and scary for both parents and teens. It is a time of increasing independence and change, no matter what the situation.

Every year, 19 million sexually transmitted infections (STIs) occur. Almost half occurs in youth aged 15 to 24. One in 4 sexually active adolescents will be infected with an STI by age 21. The prevalence of chlamydia in women aged 14 to 19 years is nearly 5%, the highest proportion of any age group. For a variety of reasons, adolescents are at high risk. STIs often have no symptoms and therefore go undiagnosed, leading to disease. If left untreated, they can cause severe health consequences, including infertility, pelvic inflammatory disease, cervical cancer, and death.

Based on these facts and recommendations from the CDC, AAP, and Nationwide Children's Hospital, **our office is encouraging the screening of all adolescents (ages 15 years and up)** for sexually transmitted infections yearly, at the time of their routine physical exams.

Fortunately, the process of this screen is relatively non-invasive and can be performed at the time of their appointment in our office. These specimens are sent to Nationwide Children's Hospital, unless otherwise requested (for example, a few insurance providers request all tests be sent to LabCorp).

As a preventative health recommendation, **most** plans cover this service at no cost to you (http://www.healthcare.gov/coverage/preventive-care-benefits/). In fact, as part of the routine exam, there is no billed charge from Westerville Pediatric Specialists, Inc. However, a charge will be billed to your insurance plan from Nationwide Children's Hospital (or other reference lab if so requested), and a few insurance policies may apply this charge toward your deductible as "patient responsibility."

_____	_____	_____
Patient's Name (printed)	***Patient's Date of Birth***	***Patient's Cell Phone Number***

I **ACCEPT** the STI screening and acknowledge having read the above information.

Date _____ Signature _____

I **DECLINE** the STI screening at this time.

Date _____ Signature _____