



## The Parent Screening Questionnaire

**Dear Parent or Caregiver:** Being a parent is not always easy.

We want to help families have a safe environment for kids. So, we're asking everyone these questions. They are about problems that affect many families. If there's a problem, we'll try to help.

Please answer the questions about your child being seen today for a checkup. If there's more than one child, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you prefer not to.

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### PLEASE CHECK

- Yes     No    Do you need the phone number for Poison Control?
- Yes     No    Do you need a smoke detector for your home?
- Yes     No    Does anyone smoke tobacco at home?
- Yes     No    In the last year, did you worry that your food would run out before you got money or Food Stamps to buy more?
- Yes     No    In the last year, did the food you bought just not last and you didn't have money to get more?
- Yes     No    Do you often feel your child is difficult to take care of?
- Yes     No    Do you sometimes find you need to hit/spank your child?
- Yes     No    Do you wish you had more help with your child?
- Yes     No    Do you often feel under extreme stress?
- Yes     No    In the past month, have you often felt down, depressed, or hopeless?
- Yes     No    In the past month, have you felt very little interest or pleasure in things you used to enjoy?
- Yes     No    In the past year, have you been afraid of your partner?
- Yes     No    In the past year, have you had a problem with drugs or alcohol?
- Yes     No    In the past year, have you felt the need to cut back on drinking or drug use?
- Yes     No    Are there any other problems you'd like help with today?

**Please give this form to the doctor or nurse you're seeing today. Thank you!**