



Well Child Check: School Aged Child (15-17 years)

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

What things delight you the most about your child?

Does your child take any medications or supplements, including vitamins? No Yes: _____

Does your child have known allergies to foods/medicines? No Yes: _____

Does your child see any specialists outside of Oberlin? No Yes: _____

Dental Health:

Does your child see a dentist 1-2 times a year? Yes No
Does your water source contain fluoride? Yes (=city water) No (=well water)

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test? No Yes

Was your child or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe)? No Yes

Does your teen have interests outside of school? Yes No

Is your teen having any problems at school? No Yes

Have you discussed ways to deal with stress? Yes No

Do you help your teen make decisions and solve problems? Yes No

Does your family get along well with each other? Yes No

Does your family do things together? Yes No

Does your teen have chores and responsibilities at home? Yes No

Do you have rules and expectations for your teen? Yes No

Do you have any concerns about your teen's nutrition, weight, or physical activity? No Yes

Does your teen talk about getting "fat" or dieting to lose weight? No Yes

Do you think your child eats healthy foods? Yes No

Do you have any difficulty getting healthy food for your family? No Yes

Do you eat meals together as a family? Yes No

Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily? No Yes

Is your child physically active at least 1 hour a day? Yes No

How much time does your teen spend on recreational screen time each day? _____

Does your teen have a TV, computer, tablet, or smartphone in his bedroom? No Yes

Do you think your teen gets enough sleep? Yes No

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| Has your teen bullied others? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Has your teen been bullied? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you know your teens friends and the activities they participate in or attend? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If your teen is in a relationship, is it respectful? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your teen tell you if someone pressured or forced them to have sex? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you noticed any changes in your teen's weight, sleep habits, or behaviors? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your teen frequently irritable? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have concerns about your teen's emotional health, such as being frequently sad or depressed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you think your teen worries too much or appears overly anxious? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you talked with your teen about relationships, dating, and sex? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you talked with your teen about his sexuality? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have house rules about curfews, parties, dating, and friends? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you know where your teen friends are and what they are doing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you talked with your teen about alcohol and drug use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| To your knowledge, is your teen currently using alcohol or drugs, or has she used them in the past? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you discussed consequences if you discover your teen is using tobacco, alcohol, or drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your teen always wear a lap and shoulder seat belt and bicycle helmet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have rules or restrictions around driving? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your teen use sunscreen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel safe in your home and community? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your partner or another significant person in your life ever hurt you or your teen? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have the things you need to take care of your teen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your home have enough heat/AC, hot water, electricity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Within the past 12 months, were you ever worried whether your food would run out? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is there anyone in your teen's life whose alcohol/drug use concerns you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your teen have access to an unlocked gun? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |