



Bright Futures Previsit Questionnaire

Early Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Do you live with anyone who uses tobacco or spend time in any place where people smoke? No Yes

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	<input type="checkbox"/> Teeth <input type="checkbox"/> Appearance or body image <input type="checkbox"/> How you feel about yourself <input type="checkbox"/> Healthy eating <input type="checkbox"/> Good ways to be active <input type="checkbox"/> How your body is changing <input type="checkbox"/> Your weight
School and Friends	<input type="checkbox"/> Your relationship with your family <input type="checkbox"/> Your friends <input type="checkbox"/> How you are doing in school <input type="checkbox"/> Girlfriend or boyfriend <input type="checkbox"/> Organizing your time to get things done
How You Are Feeling	<input type="checkbox"/> Dealing with stress <input type="checkbox"/> Keeping under control <input type="checkbox"/> Sexuality <input type="checkbox"/> Feeling sad <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Feeling irritable
Healthy Behavior Choices	<input type="checkbox"/> Smoking cigarettes <input type="checkbox"/> Drinking alcohol <input type="checkbox"/> Using drugs <input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexually transmitted infections (STIs) <input type="checkbox"/> Decisions about sex and drugs
Violence and Injuries	<input type="checkbox"/> Car safety <input type="checkbox"/> Using a helmet or protective gear <input type="checkbox"/> Keeping yourself safe in a risky situation <input type="checkbox"/> Gun safety <input type="checkbox"/> Bullying or trouble with other kids <input type="checkbox"/> Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever used marijuana or any other drug to get high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Have you ever been diagnosed with iron deficiency anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Growing and Developing

Check off all of the items that you feel are true for you.

- I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- I feel like I have at least one friend or a group of friends with whom I am comfortable.
- I help others on my own or by working with a group in school, a faith-based organization, or the community.
- I am able to bounce back from life's disappointments.
- I have a sense of hopefulness and self-confidence.
- I have become more independent and made more of my own decisions as I have become older.
- I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:



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Bright Futures Previsit Questionnaire Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Does your child have any special health care needs? No Yes, describe:

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? No Yes, describe:

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? _____

Questions About Your Child

Vision	Does your child complain that the blackboard has become difficult to see?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold books close to read?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have trouble recognizing faces at a distance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child tend to squint?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hearing	Does your child have a problem hearing over the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have trouble hearing with a noisy background?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child ask people to repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child misunderstand what others are saying and respond inappropriately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure



For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Your Growing and Developing Child

Check off all of the items that you feel are true for your child.

- My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe.
- My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
- My child has at least one friend or a group of friends with whom she is comfortable.
- My child helps others individually or by working with a group in school, a faith-based organization, or the community.
- My child is able to bounce back from life's disappointments.
- My child has a sense of hopefulness and self-confidence.
- My child has become more independent and made more of his own decisions as he has become older.
- My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:



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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name	
DRUG ALLERGIES		CURRENT MEDICATIONS	ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE
				AGE
				M F

Visit with: Teen alone Parent(s) alone Mother Father Teen with parents Other _____

History

<input type="checkbox"/> Previsit Questionnaire reviewed	<input type="checkbox"/> Teen has special health care needs
<input type="checkbox"/> Teen has a dental home	

Concerns and questions None Addressed (see other side)

Follow-up on previous concerns None Addressed (see other side)

Interval history None Addressed (see other side)

Menarche: Age _____ Regularity _____

Menstrual problems _____

Medication Record reviewed and updated

Physical Examination

= NL

Bright Futures Priority

SKIN

BACK/SPINE

BREASTS

GENITALIA

SEXUAL MATURITY RATING _____

Additional Systems

GENERAL APPEARANCE TEETH

HEAD LUNGS

EYES HEART

EARS ABDOMEN

NOSE EXTREMITIES

MOUTH AND THROAT NEUROLOGIC

NECK

Abnormal findings and comments _____

Social/Family History

See Initial History Questionnaire. No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

Assessment

Well teen

Risk Assessment

If not reviewed in Supplemental Questionnaire (Use other side if risks identified.)

HOME

Eats meals with family Yes No

Has family member/adult to turn to for help Yes No

Is permitted and is able to make independent decisions Yes No

EDUCATION

Grade _____

Performance NL _____

Behavior/Attention NL _____

Homework NL _____

EATING

Eats regular meals including adequate fruits and vegetables Yes No

Drinks non-sweetened liquids Yes No

Calcium source Yes No

Has concerns about body or appearance Yes No

ACTIVITIES

Has friends Yes No

At least 1 hour of physical activity/day Yes No

Screen time (except for homework) less than 2 hours/day Yes No

Has interests/participates in community activities/volunteers Yes No

DRUGS (Substance use/abuse)

Uses tobacco/alcohol/drugs Yes No

SAFETY

Home is free of violence Yes No

Uses safety belts/safety equipment Yes No

Has peer relationships free of violence Yes No

SEX

Has had oral sex Yes No

Has had sexual intercourse (vaginal, anal) Yes No

SUICIDALITY/MENTAL HEALTH

Has ways to cope with stress Yes No

Displays self-confidence Yes No

Has problems with sleep Yes No

Gets depressed, anxious, or irritable/has mood swings Yes No

Has thought about hurting self or considered suicide Yes No

Anticipatory Guidance

Discussed and/or handout given

PHYSICAL GROWTH AND DEVELOPMENT

- Brush/Floss teeth
- Regular dentist visits
- Body image
- Balanced diet
- Limit TV
- Physical activity

SOCIAL AND ACADEMIC COMPETENCE

- Help with homework when needed
- Encourage reading/school
- Community involvement

- Family time
- Age-appropriate limits
- Friends

EMOTIONAL WELL-BEING

- Decision-making
- Dealing with stress
- Mental health concerns
- Sexuality/Puberty

RISK REDUCTION

- Tobacco, alcohol, drugs
- Prescription drugs
- Know friends and activities
- Sex

VIOLENCE AND INJURY PREVENTION

- Seat belts, no ATV
- Guns
- Safe dating
- Conflict resolution
- Bullying
- Sport helmets
- Protective gear

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: Vision

Referral to _____

Follow-up/Next visit _____

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



Psychosocial Risks

Confidential (To be completed confidentially for teens with identified risk)

Home

Relationship with parents/guardians _____

Violence in home _____

Teen's concerns _____

Autonomy _____

Counseling/Recommendations _____

Education

Teen's concerns _____

Social interactions _____

Conflicts _____

Counseling/Recommendations _____

Eating

Usual diet _____

Attempts to lose weight by dieting, laxatives, or self-induced vomiting _____

Regular meals (includes breakfast, limits fast food) _____

Counseling/Recommendations _____

Activities

Clubs/Extracurricular _____

Music/Art _____

Sports _____

Religious/Community _____

TV/Electronics _____ hours/day

Gangs _____

Counseling/Recommendations _____

CRAFFT used with permission from Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med.* 2002;156:607-614

HEEADSSS used with permission from Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr.* 2004;21:64-90

This American Academy of Pediatrics Visit Documentation Form is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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Drugs (Substance Use/Abuse)

Tobacco use _____
Alcohol _____
Drugs (street/prescription) _____
Steroids _____
CRAFFT (+2 indicates need for follow-up)
C – Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? Yes No
R – Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? Yes No
A – Do you ever use alcohol or drugs while you are by yourself, ALONE? Yes No
F – Do you ever FORGET things you did while using alcohol or drugs? Yes No
F – Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? Yes No
T – Have you gotten into TROUBLE while you were using alcohol or drugs? Yes No
Counseling/Recommendations _____

Safety

Bullying _____
Guns _____
Dating violence _____
Passenger safety _____
Sports/recreation safety _____
Counseling/Recommendations _____

Sex

Oral sex Yes No
Has had sexual intercourse (vaginal, anal) Yes No
Age of onset of sexual activity _____
Number of partners _____ Gender of partners Male Female
Sexual orientation _____
Condom use _____ Contraception _____
Previous pregnancy No Yes _____
Previous STI No Yes _____
Laboratory/Screening results
 Pregnancy test Pap smear
 Chlamydia/Gonorrhea, source _____ Syphilis HIV
STI screening laboratory results (specify) _____

Counseling/Recommendations _____

Suicidality/Mental Health

Depression No Yes—when? _____
Anxiety No Yes—when? _____
Suicide ideation No Yes—when? _____
Suicide attempts No Yes—when? _____
History of psychologic counseling No Yes—when? _____
Other mental health diagnosis _____
Counseling/Recommendations _____

Confidentiality discussed With teen With parent(s)



Bright Futures Patient Handout

Early Adolescent Visits

Your Growing and Changing Body

- Brush your teeth twice a day and floss once a day.
- Visit the dentist twice a year.
- Wear your mouth guard when playing sports.
- Eat 3 healthy meals a day.
- Eating breakfast is very important.
- Consider choosing water instead of soda.
- Limit high-fat foods and drinks such as candy, chips, and soft drinks.
- Try to eat healthy foods.
 - 5 fruits and vegetables a day
 - 3 cups of low-fat milk, yogurt, or cheese
- Eat with your family often.
- Aim for 1 hour of moderately vigorous physical activity every day.
- Try to limit watching TV, playing video games, or playing on the computer to 2 hours a day (outside of homework time).
- Be proud of yourself when you do something good.

PHYSICAL GROWTH AND DEVELOPMENT

EMOTIONAL WELL-BEING

How You Are Feeling

- Figure out healthy ways to deal with stress.
- Spend time with your family.
- Always talk through problems and never use violence.
- Look for ways to help out at home.
- It's important for you to have accurate information about sexuality, your physical development, and your sexual feelings. Please consider asking me if you have any questions.

School and Friends

- Try your best to be responsible for your schoolwork.
- If you need help organizing your time, ask your parents or teachers.
- Read often.
- Find activities you are really interested in, such as sports or theater.
- Find activities that help others.
- Spend time with your family and help at home.
- Stay connected with your parents.

SOCIAL AND ACADEMIC COMPETENCE

Violence and Injuries

- Always wear your seatbelt.
- Do not ride ATVs.
- Wear protective gear including helmets for playing sports, biking, skating, and skateboarding.
- Make sure you know how to get help if you are feeling unsafe.
- Never have a gun in the home. If necessary, store it unloaded and locked with the ammunition locked separately from the gun.
- Figure out nonviolent ways to handle anger or fear. Fighting and carrying weapons can be dangerous. You can talk to me about how to avoid these situations.
- Healthy dating relationships are built on respect, concern, and doing things both of you like to do.

VIOLENCE AND INJURY PREVENTION

Healthy Behavior Choices

- Find fun, safe things to do.
- Talk to your parents about alcohol and drug use.
- Support friends who choose not to use tobacco, alcohol, drugs, steroids, or diet pills.
- Talk about relationships, sex, and values with your parents.
- Talk about puberty and sexual pressures with someone you trust.
- Follow your family's rules.

RISK REDUCTION



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Bright Futures Parent Handout Early Adolescent Visits

Here are some suggestions from Bright Futures experts that may be of value to your family.

Your Growing and Changing Child

PHYSICAL GROWTH AND DEVELOPMENT

- Talk with your child about how her body is changing with puberty.
- Encourage your child to brush his teeth twice a day and floss once a day.
- Help your child get to the dentist twice a year.
- Serve healthy food and eat together as a family often.
- Encourage your child to get 1 hour of vigorous physical activity every day.
- Help your child limit screen time (TV, video games, or computer) to 2 hours a day, not including homework time.
- Praise your child when she does something well, not just when she looks good.

Healthy Behavior Choices

RISK REDUCTION

- Help your child find fun, safe things to do.
- Make sure your child knows how you feel about alcohol and drug use.
- Consider a plan to make sure your child or his friends cannot get alcohol or prescription drugs in your home.
- Talk about relationships, sex, and values.
- Encourage your child not to have sex.
- If you are uncomfortable talking about puberty or sexual pressures with your child, please ask me or others you trust for reliable information that can help you.
- Use clear and consistent rules and discipline with your child.
- Be a role model for healthy behavior choices.

Feeling Happy

EMOTIONAL WELL-BEING

- Encourage your child to think through problems herself with your support.
- Help your child figure out healthy ways to deal with stress.
- Spend time with your child.
- Know your child's friends and their parents, where your child is, and what he is doing at all times.
- Show your child how to use talk to share feelings and handle disputes.
- If you are concerned that your child is sad, depressed, nervous, irritable, hopeless, or angry, talk with me.

School and Friends

SOCIAL AND ACADEMIC COMPETENCE

- Check in with your child's teacher about her grades on tests and attend back-to-school events and parent-teacher conferences if possible.
- Talk with your child as she takes over responsibility for schoolwork.
- Help your child with organizing time, if he needs it.
- Encourage reading.
- Help your child find activities she is really interested in, besides schoolwork.
- Help your child find and try activities that help others.
- Give your child the chance to make more of his own decisions as he grows older.

Violence and Injuries

VIOLENCE AND INJURY PREVENTION

- Make sure everyone always wears a seat belt in the car.
- Do not allow your child to ride ATVs.
- Make sure your child knows how to get help if he is feeling unsafe.
- Remove guns from your home. If you must keep a gun in your home, make sure it is unloaded and locked with ammunition locked in a separate place.
- Help your child figure out nonviolent ways to handle anger or fear.



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