This clinic is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child’s medical record. **If more than one of your children is being seen today, you only need to fill out this questionnaire once.** Please circle your answer.

1. **Are you the child’s**
   - Mother
   - Father
   - Grandparent
   - Foster parent
   - Other relative
   - Other ____________________________

2. **What is the highest grade you completed?**
   - 1  2  3  4  5  6  7  8  9  10  11  12
   - High School
   - GED
   - Some College or Vocational School
   - College grad or above

3. **Does this child live primarily in your home?**
   - Yes
   - No

4. **Does your income support your family’s basic needs?**
   - Yes
   - No

5. **Do you have any major housing problems?**
   - No
   - Currently homeless
   - At risk of losing housing
   - Unhealthy conditions in home

6. **Do you worry that your environment is not safe for your child?**
   - Yes
   - No

7. **Have you ever worried that your food will run out before you get more funds?**
   - Yes
   - No

8. **Where do you get emotional support?** (Circle all that apply)
   - Family
   - Friends
   - Faith or religious group
   - Other ____________________
   - No support

9. **Over the last 2 weeks, how many days have you felt down, depressed or hopeless?**
   - A) No days
   - B) Several days
   - C) More than half the days
   - D) Nearly every day

10. **Over the last 2 weeks, how many days have you felt almost no interest or pleasure in doing things?**
    - A) No days
    - B) Several days
    - C) More than half the days
    - D) Nearly every day

11. **In the past year has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you?**
    - Yes
    - No

12. **Do you worry that your child has been physically or sexually abused?**
    - Yes
    - No

**TURN OVER TO COMPLETE PAGE 2!**
13. Do you or your partner have a drinking or drug problem?
   Yes   No

14. Have you tried to cut down on alcohol in the past year?
   Yes   No   Don’t drink

15. How often do you spank your child?
   A) Not at all  B) Once in a week or less  C) Many days  D) Nearly every day

16. What makes it difficult to get medical care for your child?
   (Circle all that apply)
   A) No problems getting care  B) Insurance/Medicaid  C) My health condition
   D) Transportation  E) My job  F) Childcare  G) Problem scheduling with my doctor
   H) Other ____________________________________________

17. Would you like help with any of these issues?  (Circle all that apply)
   A) Finding daycare  B) Finding preschool  C) Child’s school/IEP issues  D) Car seat
   E) Medical equipment  F) My own schooling  G) Child custody issues  H) Job training
   I) Faith concerns  J) Denial of SSI or public benefits (e.g. food stamps, TANF, WIC, etc.)
   Other ____________________________________________

Parents stop here.  Thanks!  Section below is for healthcare provider to complete.

Provider: In the Sick Visit section of problem list, record “FRS complete” with visit data. Note “no concerns” or relevant concern(s) which were identified along with any acute illnesses. Note action(s) taken below:

☐ Handout given (check which ones)
   General Community Resources (Handout 1)  ____
   Choosing Daycare  ____
   Working With Your Child’s School  ____
   Other (list topic) ________________________________

☐ Referral to Behavioral Health Coordinator

☐ Referral to Social Work

☐ Referral to Health and Law Partnership (HeLP)

☐ Referral to Family Resource Library (list issue) ________________________________

☐ Other (list): ________________________________
   ________________________________
   ________________________________

☐ No concerns identified

Provider Signature   Date   Time