Questionnaire for Parents or Guardians

Chart # _____
Label

This questionnaire will help us get to know your adolescent better. This Questionnaire is completely confidential. The answers will be evaluated only by the staff of _____. Your honest response to these questions will help us to better serve you. Also your responses serve for future studies; however in this case the information would be published without revealing your name or identity. Adapted from GAPS, Guidelines for Adolescent Preventive Services.

Date_____
(month, day, year)

Your adolescent's birthdate_____ Sex: ☐ Male ☐Female Age: _____
(month, day, year)

Your information: Sex: ☐ Male ☐Female Age: _____

Indicate which of these ethnic groups **you** identify with: ☐Latino/Hispanic ☐White/Caucasian

☐African-American ☐Native American ☐Asian ☐Other

In which country were **you** born? _____

Name of adolescent _____

Name of parent/guardian _____ Relation to adolescent _____

Home phone number: _____ Alternate number/work/cell_____

What is the best time to call you? _____

How long have you lived in the US?

☐ Less than 6 months ☐6 months-1 year ☐2 years ☐3 years ☐4 years

☐5 years or more ☐ I was born here

How long has your adolescent lived in the US?

☐ Less than 6 months ☐6 months-1 year ☐2 years ☐3 years ☐4 years

☐5 years or more ☐ he/she was born here

Do **you** speak English? ☐ Yes ☐ No

If 'No', tell us if someone is able to translate for you, his or her name and relation to you?

☐ Adolescent ☐ Another member of the family ☐ other (who) _____

Please indicate your level of education:

☐I never went to school ☐Some Elementary school ☐Elementary

☐Some middle/high school ☐High school graduate ☐College or University

How many hours a week do you work?

☐I don't work ☐10-20 hours ☐20-30 hours ☐30-40 hours ☐More than 40 hours

Medical History

1. Does your adolescent have any known drug allergies? ☐Yes ☐ No

   To which drugs?

_____

2. Has your adolescent ever been hospitalized? ☐Yes ☐ No

   At what age, and why: _____

3. Has your adolescent ever had a serious injury? ☐Yes ☐ No

   Explain: _____

4. Have you noted changes in your adolescent's health in the past year? ☐ Yes ☐ No

☐Diabetes ☐Asthma ☐Rheumatic Fever ☐Overweight/Obesity ☐Dyslexia ☐Depression

☐Anxiety ☐Panic Attacks ☐Schizophrenia ☐Attention Deficit Disorder/Hyperactivity

☐Anorexia/Bulimia ☐Other/Explain_____

Additional Information

5. Who has your adolescent lived with for the majority of the past year? Mark all that apply.

☐ Both parents in the same house	☐ Stepmother	☐ Mother
☐ Other adult relative _____	☐ Stepfather	☐ Father
☐ Siblings (please indicate ages) _____		☐ Alone
☐ Legal Guardian	☐ Other: _____	

6. In the past 12 months, have there been any significant changes in the family? Mark all that apply.

☐ Marriage	☐ Loss of work	☐ Serious illness
☐ Birth	☐ Move to new neighborhood	☐ Change of school or college
☐ Separation	☐ Move to new country	☐ Death
☐ Divorce	☐Other: _____	

7. Did you know that telling an adolescent how important they are to their parents and family gives them self-confidence and better prepares them for the future? ☐Yes ☐ No

Do you let them know often? ☐Yes ☐ No

8. Which of these topics do you find hardest to talk about with your adolescent?

(Mark all that apply)

☐Sexuality and sexually transmitted diseases

☐ Drugs and alcohol

☐ Unplanned pregnancy

☐Healthy relationships with friends and partners

☐The hormonal and emotional changes that occur during adolescence

☐Depression

☐Peer pressure and the influence of friends

☐Other_____

☐ None of the above

9. Which of these topics would you like more information on?

_____ ☐ None

10. Have you talked to your adolescent about the prevention of alcohol and drug use? ☐Yes ☐ No

11. Do you think your adolescent has used some sort of drug or consumed alcohol? ☐Yes ☐ No

12. Would you like your adolescent to go to college? ☐Yes ☐ No

13. Have you made plans for your adolescent to go to college? ☐Yes ☐ No

14. If you have not made plans for post secondary education, please indicate why:

☐We don't have enough money ☐He/she only wants to work

☐He/she is not interested ☐Other/Explain_____

15. Do you talk to your adolescent about their friends and do you promote healthy relationships?

☐Yes ☐ No

16. Do you establish clear and reasonable limits for your adolescent?.....☐Yes ☐ No

(For example, does your adolescent have a clear understanding of when they can go out with their friend during the week? Also, does he/she feel like you understanding and respect the importance their friends have at this stage of their life.)

17. Do you share your beliefs, values, and opinions of the things that happen in the world today with your adolescent?..... ☐Yes ☐ No

18. Do you keep healthy foods like fruits, vegetables, and high-fiber foods available for your adolescent?.....☐Yes ☐ No

19. Would you like a consultation with our nutritionist about how to maintain a healthy, balanced diet?.....☐Yes ☐ No

20. Do you talk about sexuality and prevention of pregnancy and sexually transmitted diseases with your adolescent?.....☐Yes ☐ No

21. How **comfortable** do you feel talking to your adolescent about sex, drugs, or violence?

☐Very Comfortable ☐Somewhat comfortable ☐ Uncomfortable

22. Do you believe that you respect your adolescent's privacy?.....☐Yes ☐ No

23. How would you rate the communication between you and your adolescent?

☐Excellent ☐ Good ☐ Fair ☐ Difficult ☐ Nonexistent

24. Do you believe that your adolescent is bullied or teased at school?.....☐Yes ☐ No
☐ Don't know ☐ He/She is not attending school

25. Do you believe that your adolescent bullies or teases others at school?.....☐Yes ☐ No
☐ Don't know ☐ He/She is not attending school

26. Would you like information about support groups for parents?.....☐Yes ☐ No

27. Would you be interested in attending such a group?.....☐Yes ☐ No

28. What are your biggest concerns at the moment?

☐Lack of work ☐Lack of money ☐Health problems in the family ☐Security/Violence

☐Other/Explain:_____ ☐ No concerns at this time

29. Would you like to discuss something specific with us today? ☐ Yes ☐ No

If 'yes', what would you like to discuss: _____

_____

30. What about your adolescent makes you feel proud? _____

_____

_____

Would you allow us to show your response to #30 to your adolescent?.....☐Yes ☐ No

31. What are your adolescent's most difficult personal challenges? _____

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32. Is there some aspect of your relationship with your adolescent that you would like to improve?

☐ Yes ☐ No If 'yes', what would you like to improve? _____

Why do you think this happened? _____

What are the barriers that impede your having a good relationship?

_____

_____

_____

33. What do you think are the most important things that every parent of an adolescent should know?_____

_____

34. How much do you believe your adolescent knows about sexuality (Prevention of unwanted pregnancy, hormonal changes, changes in patterns of socialization, etc.)?

☐A lot ☐Some ☐Nothing

35. What your adolescent knows about pregnancy prevention was learned primarily from: (Mark one option only)

☐ Parents or family ☐School ☐Television or other mass communication

☐Friends ☐Other_____

36. Are you aware of a law in the state of Minnesota that allows adolescents to obtain medical services in a confidential manner when the services pertain to: family planning, prevention and treatment of sexually transmitted diseases, and drug and alcohol dependency?..……..…….. ☐ Yes ☐ No

37. Do you agree with this law?..... ☐ Yes ☐ No

38. Would you like more information about this law?..... ☐ Yes ☐ No

39. Indicate the topics about which **you** would like more information:

- ☐ Family planning
- ☐ Eating disorders
- ☐ Growth and development evaluation
- ☐ Risk factor reduction
- ☐ Depression
- ☐ Sexually transmitted diseases
- ☐ Complete physical exam
- ☐ Diet and healthy weight control
- ☐ Use of tobacco, alcohol, and drugs
- ☐ HIV/AIDS
- ☐ None

40. Indicate the topics about which you think your adolescent needs more information:

- ☐ Family planning
- ☐ Eating disorders
- ☐ Growth and development evaluation
- ☐ Risk factor reduction
- ☐ Depression
- ☐ Sexually transmitted diseases
- ☐ Complete physical exam
- ☐ Diet and healthy weight control
- ☐ Use of tobacco, alcohol, and drugs
- ☐ HIV/AIDS
- ☐ None