

**Check (✓) all that you need help with today**

**1) Do you have questions or concerns about your child's health or health related needs?**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Adaptive Equipment    | <input type="checkbox"/> Bowel/Bladder   | <input type="checkbox"/> Breathing or Heart             | <input type="checkbox"/> Hearing/Seeing    |
| <input type="checkbox"/> Medical Supplies      | <input type="checkbox"/> Medications     | <input type="checkbox"/> Muscle Tone                    | <input type="checkbox"/> Nutrition/Feeding |
| <input type="checkbox"/> Orthotics/Prosthetics | <input type="checkbox"/> Pain/Discomfort | <input type="checkbox"/> Pressure Garments              | <input type="checkbox"/> Skin/Wounds       |
| <input type="checkbox"/> Sleeping              | <input type="checkbox"/> Treatment Plan  | <input type="checkbox"/> Understanding Health Condition |  |
| <input type="checkbox"/> Weight                | <input type="checkbox"/> Other _____     |   |  |

**2) Do you have questions or concerns about your child's development?**

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Bathing        | <input type="checkbox"/> Communication/speech | <input type="checkbox"/> Doing Chores   | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Eating         | <input type="checkbox"/> Learning Self-care   | <input type="checkbox"/> Making Friends | <input type="checkbox"/> Mobility |
| <input type="checkbox"/> Potty Training | <input type="checkbox"/> Progress at School   | <input type="checkbox"/> Toileting      |                                   |
| <input type="checkbox"/> Other _____    |   |   |                                   |

**3) Are you concerned that your child is at risk for:**

- |   |  |                                   |                                     |                                     |
|---|--|-----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Anger                | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Bullying | <input type="checkbox"/> Depression | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Risk Taking Behavior | <input type="checkbox"/> Other _____         |                                   |                                     |                                     |

**4) Do you need information about how to find or obtain any of the following services or resources?**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Day Care/Child Care       | <input type="checkbox"/> Dental Care                 | <input type="checkbox"/> Early Intervention    | <input type="checkbox"/> Food                  |
| <input type="checkbox"/> Health Insurance/Medicaid | <input type="checkbox"/> Housing                     | <input type="checkbox"/> Mental Health Service | <input type="checkbox"/> Primary Care Doctor   |
| <input type="checkbox"/> Recreation/Sports         | <input type="checkbox"/> Respite Care/Attendant Care | <input type="checkbox"/> School Services       | <input type="checkbox"/> Specialty Care Doctor |
| <input type="checkbox"/> SSI                       | <input type="checkbox"/> State CSHCN Prog            | <input type="checkbox"/> Support Group         | <input type="checkbox"/> Transportation        |
| <input type="checkbox"/> Vocational Rehab          | <input type="checkbox"/> Other _____                 |  |  |

**5) Do you have questions or concerns about your child's future?**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Community Participation | <input type="checkbox"/> Health          | <input type="checkbox"/> Job/Career       | <input type="checkbox"/> Living Independently |
| <input type="checkbox"/> Medical Care            | <input type="checkbox"/> Quality Of Life | <input type="checkbox"/> Sexuality Issues | <input type="checkbox"/> Transportation       |
| <input type="checkbox"/> Other _____             |  |   |   |

**6) Staff I need to see today?**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Care Coordinator   | <input type="checkbox"/> Nurse                  | <input type="checkbox"/> Nutritionist  | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Prosthetic & Orthotics | <input type="checkbox"/> Social Worker |   |

**7) Other questions or concerns?**

**8) I would like to see someone  Today or  Next Visit about these concerns**

Parent Screening Tool

Pilot, Lexington

02/03

Addressograph

**Check (✓) all that you need help with today**

**1) Do you have questions or concerns about your health or health related needs?**

- Bowel/Bladder
- Medical Supplies
- Nutrition/Feeding
- Pressure Garments
- Sleeping
- Understanding Health Condition
- Breathing or Heart
- Medications
- Orthotics/Prosthetics
- Sexual Reproductive Functioning
- Treatment Plan
- Other \_\_\_\_\_
- Hearing/Seeing
- Muscle Tone
- Pain/Discomfort
- Skin/Wounds

**2) Do you have questions or concerns about your independence in:**

- Bathing
- Eating
- Potty Training
- Speaking up for Yourself
- Other \_\_\_\_\_
- Communication/speech
- Independent Living Skills
- School/community
- Toileting
- Doing Chores
- Making Friends
- Self-care
- Dressing
- Mobility

**3) Are you concerned or do you have questions about:**

- Anger
- Risk Taking Behavior (such as smoking, drinking or drugs)
- Violence at Home or School
- Bullying
- Depression
- Loneliness
- Other \_\_\_\_\_

**4) Do you need information about how to find or obtain any of the following services or resources?**

- Attendant Care
- Housing
- School Services
- Support Group
- Other \_\_\_\_\_
- Dental Care
- Mental Health Service
- Specialty Care Doctor
- Transportation
- Food Stamps
- Primary Care Doctor
- State CSHCN Program
- Vocational Rehabilitation
- Health Insurance/Medicaid
- Recreation/Sports
- SSI

**5) Do you have questions or concerns about your future?**

- Community Participation
- Medical Care
- Transportation
- Health
- Quality Of Life
- Other \_\_\_\_\_
- Job/Career
- Sexuality Issues
- Living Independently
- School/College

**6) Staff I need to see today?**

- Care Coordinator
- Physical Therapist
- Nurse
- Prosthetic & Orthotics
- Nutritionist
- Social Worker
- Occupational Therapist

**7) Other questions or concerns?**

**8) I would like to see someone  Today or  Next Visit about these concerns**