Dear Parent or Caregiver: Being a parent is not easy. We want to help families have a safe environment for kids. We are asking everyone these questions. Please answer the questions about your child being seen today for a check-up. They are about issues that affect many families. If there’s a problem, we’ll try to help.

Today’s Date: _____/____/200_  
Child’s Date of Birth: _____/____/_____  
Sex of Child: □ Male □ Female

PLEASE CHECK  
□ Yes □ No  Do you need the telephone number for Poison Control?  
□ Yes □ No  Do you need a smoke alarm for your home?  
□ Yes □ No  Does anyone smoke tobacco at home?  
□ Yes □ No  Is there a gun in your home?  
□ Yes □ No  In the last year, did you worry that your food would run out before you got money, or food stamps to buy more?  
□ Yes □ No  Do you worry that your child may have been physically abused?  
□ Yes □ No  Do you worry that your child may have been sexually abused?  
□ Yes □ No  Lately, do you often feel down, depressed, or hopeless?  
□ Yes □ No  Do you often feel lonely?  
□ Yes □ No  During the past month, have you felt little interest or pleasure in the things you used to enjoy?  
□ Yes □ No  Do you often feel your child is difficult to take care of?  
□ Yes □ No  Do you wish you had more help with your child?  
□ Yes □ No  Do you feel so stressed you can’t take another day?  
□ Yes □ No  Do you sometimes find you need to hit/spank your child?  
□ Yes □ No  In the past year, have you or your partner had a problem with drugs or alcohol?  
□ Yes □ No  In the past year, have you or your partner felt the need to cut back on drinking or drug use?  
□ Yes □ No  Have you ever been in a relationship in which you were physically hurt or threatened by a partner?  
□ Yes □ No  In the past year, have you been afraid of a partner?  
□ Yes □ No  In the past year have you thought of getting a court order for protection?  
□ Yes □ No  Are there any problems you’d like help with today?

Please give this form to the doctor or nurse you’re seeing today. Thank you

_________________________________________________________  
Provider’s name, PRINTED  Provider’s Signature  Date