Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

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Parent/Guardian Name (print) Signature Date

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Charlene C. Blache, M.D.
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Date

Child's Name

Date of Birth

PHQ-2

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless.	◯	◯	◯	◯

STOP HERE if you ANSWERED "not at all" to the above 2 questions!

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
3. Trouble falling or staying asleep, or sleeping too much.	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating.	◯	◯	◯	◯
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television.	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all	Somewhat difficult	Very difficult	Extrememly difficult

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
FIRST WEEK VISIT (3 TO 5 DAYS)

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. 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? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your family's life? ○ **No** ○ **Yes,** describe:

Have any of your baby's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING BABY

Do you have specific concerns about your baby's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your baby is able to do.

- ☐ Stay awake for a short time to feed.
- ☐ Make brief eye contact with an adult when held.
- ☐ Cry when she is uncomfortable.
- ☐ Calm to an adult's voice.
- ☐ Lift and turn his head to the side briefly when he is on his tummy.
- ☐ Move her arms and legs at the same time when startled.
- ☐ Keep his hands in a fist.

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PATIENT NAME: _____ DATE: _____

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FIRST WEEK VISIT (3 TO 5 DAYS)

RISK ASSESSMENT

Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	O Yes	O No
Does your home have enough heat, hot water, and electricity?	O Yes	O No
Do you have health insurance for yourself?	O Yes	O No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Do you need help in finding community support services, such as WIC or food stamps?	O No	O Yes
Family Support		
Do you search the Internet to learn about how to care for your baby?	O No	O Yes

GETTING TO KNOW YOUR BABY

How You Are Feeling		
Do you sleep when the baby sleeps?	O Yes	O No
Does your partner or do other family members help with the baby?	O Yes	O No
If you have other children, are you able to spend time with them? O NA	O Yes	O No

CARING FOR YOUR BABY

Do you read to your baby?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?	O No	O Yes
Is your baby able to fully awaken for feedings?	O Yes	O No
Do you have questions about how to calm your baby?	O No	O Yes
When to Call Your Doctor/Emergency Planning		
Do you know how to take your baby's temperature rectally?	O Yes	O No
Do you have a list of emergency phone numbers?	O Yes	O No
Do you have any questions about taking your baby out in public places?	O No	O Yes

FEEDING YOUR BABY

General Information		
Does your baby feed well?	O Yes	O No
Do you have any questions about how your baby is growing?	O No	O Yes
Are you having problems burping your baby?	O Yes	O No
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No
Does your baby have 5 or 6 wet disposable diapers (or 6–8 cloth diapers) and 3 or 4 stools a day?	O Yes	O No

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FIRST WEEK VISIT (3 TO 5 DAYS)

FEEDING YOUR BABY (*CONTINUED*)

If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	O No	O Yes
Do you eat foods that are high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No
Are you continuing to take prenatal vitamins?	O Yes	O No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes
Are you giving your baby vitamin D drops?	O Yes	O No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	O Yes	O No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	O No	O Yes

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	O Yes	O No
Are you having any problems with your car safety seat?	O No	O Yes
Have you started developing habits that will help prevent you from ever forgetting your baby in the car?	O Yes	O No
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	O Yes	O No
Safe Sleep		
Does your baby sleep on his back?	O Yes	O No
Does your baby sleep in a crib?	O Yes	O No
Does your baby sleep in your room?	O Yes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit,* 2nd Edition.

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