Children's Healthcare of Atlanta
at Hughes Spalding

FAMILY RESOURCES SURVEY

Patient Name: _____

Date of Birth: _____

AFFIX LABEL

Medical Record #: _____

Date of Service: _____

PATIENT IDENTIFICATION

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 <u>almost no interest or pleasure</u> 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

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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