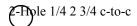


Yes

No



Children's Healthcare of Atlanta at Hughes Spalding

FAMILY RESOURCES SURVEY

Patient Name:
Date of Birth:
Medical Record #: X LABEL
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.

need to fin out the questioniane ones. I loads ones 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.	4. Does your income support your family's basic needs? Yes No				
5.	5. Do you have any major housing problems?No Currently homeless At risk of losing housing Unhealthy conditions in home				
6.	6. Do you worry that your environment is not safe for your child? Yes No				
7.	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 almost no interest or pleasure 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	12. Do you worry that your child has been physically or sevually abused?				

TURN OVER TO COMPLETE PAGE 2!

13. Do you or your partner have a drinking or drug problem? Yes No						
14.	4. Have you tried to cut down on alcohol in the past year? Yes No Don't drink					
15.	5. 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.	6. 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 A) Finding daycare B) Finding preschool C) Child's school E) Medical equipment F) My own schooling G) Child custool Figure 1) Faith concerns J) Denial of SSI or public benefits (e.g. food Other 	ool/IEP issues D) Ca dy issues H) Job tra	ining			
Par	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						
Pro	Provider Signature Date	Time				