



Background information questionnaire for a health examination for the parents of 8th grade pupils

Your child will soon have a health examination in school health care. The extensive health examination includes discussing the health and welfare of the child and his or her entire family. We also take aspects related to the child's school attendance and leisure time into account. We invite parents to participate in the child's extensive health examination. Your participation is very important.

We wish that you fill out this form and return it based on the included instructions. When a child lives in two homes, both homes can fill out separate forms. While the questionnaire has been planned to be filled out by parents, you may also discuss with your child when considering your answers. The questions will help you gain an understanding of the content of the health examination. Your replies help us target the health examination based on your family's needs and wishes. We will discuss the topics of the form during the examination. Your child will also fill out a separate form related to the health examination.

Filling out the form and answering each individual question is voluntary. The information you provide is confidential and subject to the secrecy provisions of health care. Information regarding the health examination will be entered in patient documents, after which the preliminary information forms will be destroyed. School health care documents are part of the health centre's patient document register.

Pupil:

Name _____ Class _____
Personal identity code _____ Language(s) used at home _____

Parents/guardians:

Telephone number where you can be reached
during the day _____

Name _____
Name _____

The child lives

- with both parents
 with his/her mother
 with his/her father
 other arrangements, please specify:

Changes in the family structure

- no changes
 separated/divorced in _____
 joint custody
 single parent mother/father (please circle)
 new cohabitation/marriage in _____
 other, please specify: _____

Meeting arrangements during parents' separation

Does your child have siblings?

- no yes, names and years of birth

Other persons belonging to the family or same household

CHILD'S HEALTH AND WELLBEING

How would you assess your child's current health? good average poor

Does your child have some long-term (physical or mental) symptom, illness or disability?
 no yes, please specify: Care provider, and current treatments and limitations

- allergy no yes _____
- special diet no yes _____
- medication in use no yes _____

During the past year, has your child repeatedly suffered from?

- tiredness or sleeping difficulties no yes
- tenseness or nervousness no yes
- violent behaviour, aggressiveness no yes
- restlessness, difficulties concentrating no yes
- fears, anxiety no yes
- melancholy, isolation from others no yes
- pain under physical strain no yes
- other symptoms, ailments or pains no yes
- accidents no yes

Has your child ever lost consciousness while lying down or under physical strain? no yes

Does your child's family have any history of hereditary or recurring illnesses or sudden deaths at the age of under 50?
 no yes _____

Have you discussed the following themes with your child?

- puberty yes no
- sexuality yes no
- dating yes no
- contraception yes no

HEALTH HABITS

Our child

- **sleeps** on school days around _____ hours per night
on weekends around _____ hours per night
- **engages in physical activity** each day around _____ hours (getting to and from school and physical education at school, spending time outdoors and leisure time activities involving sport)
- **screen time** on school days _____ hours/day (smartphones, TV, computers, gaming consoles and other devices)
on weekends _____ hours/day

Do you know what your child does on the Internet? yes no

Our family's eating habits

what is good _____

what should be developed _____

Our child's meals	on school days	on weekends
breakfast	<input type="checkbox"/>	<input type="checkbox"/>
school meal/lunch	<input type="checkbox"/>	<input type="checkbox"/>
afternoon snack	<input type="checkbox"/>	<input type="checkbox"/>
dinner	<input type="checkbox"/>	<input type="checkbox"/>
bedtime snack	<input type="checkbox"/>	<input type="checkbox"/>

Our child uses

dairy and/or dairy products
vitamin D
energy drinks

<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> yes	<input type="checkbox"/> no

Use of tobacco products and intoxicants in our family:

- tobacco no yes _____
- snus (Swedish type moist snuff) no yes _____
- alcohol no yes _____
- drugs no yes _____

Has your child experimented with or used tobacco products or intoxicants? no I don't know yes _____

Is there tobacco, snus, alcohol or drug use in your child's circle of friends? no I don't know yes _____

SCHOOL

How is your child's school attendance and homework going?

What are your child's strengths at school?

Is your child's learning supported (remedial teaching, small group, special needs education etc.)? no yes, please specify:

Is your child seeing/has your child been seeing a school social worker or a school psychologist?

no yes, why?

How do you feel the cooperation between home and school is going?

- Does your child enjoy going to school? yes I don't know no
- Does your child have friends at school? yes I don't know no
- Is your child being bullied at school? yes I don't know no
- Has your child participated in bullying at school? yes I don't know no
- Has your child been a victim of violence or sexual harassment at school? yes I don't know no

LEISURE TIME

What does your child do during his/her leisure time? (alone/together with friends/family or as recreational activities)

Our child's curfew is at _____ on school days and at _____ on weekends

- Does your child have friends during leisure time? yes no
- Do you know any of your child's friends? yes no
- Do you know where and with whom your child spends his/her leisure time? yes no
- Is your child being bullied during leisure time? yes I don't know no
- Has your child participated in bullying during leisure time? yes I don't know no
- Has your child been a victim of violence or sexual harassment during leisure time? yes I don't know no



FAMILY

Does your family spend enough time together?
How do you spend it?

 yes

 no

Our family

- tends to give encouragement and positive feedback yes no
- shares household chores yes no
- is safe for everyone and has a generally amicable atmosphere yes no
- tends to share what has happened during the day yes no
- has agreed on rules together yes no
- eats a meal together every day yes no

How does your family solve situations where a child has broken agreed rules or is misbehaving?

Do you feel you need help in matters concerning your child's upbringing?

 No

 Yes, what kind of help? _____

 We are already receiving/have received support, from whom? (e.g. a child guidance and family counselling clinic) _____

All worries, issues taking up resources and changes in the family affect the pupil's welfare and coping at school.

In your family, is there?

- long-term illnesses (physical or mental) no yes
- difficulties coping, exhaustion or depression no yes
- insecurity or violence no yes
- substance abuse issues or addiction no yes
- problems in relationships between family members no yes
- financial worries no yes
- grief or losses no yes
- some other current issues; please specify: _____

Our family's strengths _____

What about your child delights you? _____

Your wishes for the health examination _____

_____ Date

_____ Signature of the person(s) who filled out the questionnaire

