6 Year Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have any concerns about your child's health?	NO	YES
2	Does your child receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

3	Is your child eating 5 servings of fruits and vegetables daily?	YES	NO
4	When your child has grains (cereal, bread, pasta, crackers, waffles, rice, etc.) are they mostly whole grains?	YES	NO
5	Does your child eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese)?	YES	NO
6	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than 2-3 times per week?	NO	YES
7	Does your child drink soda, juice, or other sweetened drinks more than once or twice per week?	NO	YES
8	Does your child snack more than 1-2 times a day on foods other than fruits and vegetables?	NO	YES
9	Do you give your child any vitamins or supplements?	NO	YES
10	Are you worried about your child's weight?	NO	YES

Oral Health

11	Does your child see a dentist at least 2 times a year? **(If your answer is yes, please skip ahead to #16)**	YES	NO	
	ANSWER #15-18 *ONLY* IF YOUR CHILD DOES *NOT* SEE A DENTIST			
12	Has any caregiver had cavities/dental decay in the past year?	NO	YES	
13	Does your child drink something other than water from a cup continually and/or snack frequently throughout the day?	NO	YES	
14	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO	NOT SURE
15	Do your brush your child's teeth with a fluoride-containing toothpaste (size of a pea) twice daily?	YES	NO	

Lipids

16 Does your child have a parent who has had a stroke or heart attack before age 55?	NO	YES
17 Does your child have a parent or sibling with high cholesterol?	NO	YES

Elimination

18 Does your child have regular soft bowel movements (poop)?	YES	NO

School

19 Is your child having any problems with progress in school or ability to learn?	NO	YES
20 Is your child having any problems with sitting all day or concentrating on schoolwork?	NO	YES
21 Is your child having any problems with getting along with teachers?	NO	YES
22 Is your child having any problems with happiness, self-esteem, self-confidence?	NO	YES
23 Is your child having any problems with peer relationships (lack of friends, bullying)?	NO	YES
24 Does your child have an IEP or other learning plan?	NO	YES

Activity / Exercise / Screen Time

25 Does your child have more than 2 hours of screen time per day (TV, smartphones, tablets)?	NO	YES
26 Does your child have any screen time in his/her bedroom?	NO	YES
27 Do you read to your child every day?	YES	NO
28 Do you and your family do active and educational activities like walking, bicycling, swimming, going to libraries or going on nature walks?	YES	NO
29 Do you eat meals together as a family?	YES	NO
30 Does your child play actively for at least 1 hour every day?	YES	NO
31 Does your child have a hard time falling asleep or staying asleep at night?	NO	YES
32 Is your child sleeping 9-11 hours at night?	YES	NO

Social Stressors

33 Have there been any major changes or stresses in your family recently?	NO	YES	
34 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES

35	Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
36	Is there someone in your life that hurts you or your children?	NO	YES	

Safety

37	Do you have rules about internet safety? Do you have parental controls set?	YES	NO	
38	Do you have rules about answering the door and phone at home?	YES	NO	
39	Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
40	Does anyone smoke or vape around your child?	NO	YES	
41	Is there a gun in the home?	NO	YES	
	a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY
42	If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15 to 30 minutes?	YES	NO	DOESN'T APPLY
43	Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
44	Does your child use a child safety seat or booster seat when in the car?	YES	NO	
45	Do you have a home fire escape plan?	YES	NO	

Tuberculosis

46	Has a family member or contact had tuberculosis disease (TB)?	NO	YES
47	Has a family member ever had a positive TB skin test (PPD)?	NO	YES
48	Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
49	Has your child traveled to a high-risk country for more than a month?	NO	YES

Review of Systems

50	Do you have any concerns about your child's eating habits, weight loss, or lack of energy?	NO	YES
51	Does your child have any sleep problems, including a lot of snoring?	NO	YES
52	Do you have concerns about your child's eyes or vision?	NO	YES
53	Does your child have recurrent (many) ear, sinus or throat infections, or nosebleeds?	NO	YES
54	Does your child have chest pain, shortness of breath, or irregular heartbeat?	NO	YES

55	Are you concerned about your child's lungs or breathing?	NO	YES
56	Does your child complain about abdominal (tummy) pain, vomiting, diarrhea, constipation?	NO	YES
57	Does your child have kidney or bladder problems, infections, blood in the urine?	NO	YES
58	Do you have concerns about your child's skin, hair, or nails?	NO	YES
59	Does your child complain about joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
60	Does your child have recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
61	Does your child have anxiety, mood changes, sadness, nervous problems?	NO	YES
62	Does your child have excessive thirst or increased urination?	NO	YES
63	Does your child have easy bruising, swollen glands, or look pale?	NO	YES
64	Is your child showing any signs of puberty (breast development, hair in pubic areas or armpits, testicle enlargement)?	NO	YES