Well child

Pre-visit questionnaire

6 year

General

1.	List any concerns you want to discuss today:		
2.	Does your child have screen time (smartphone, tablet, TV) more than 2 hours daily?	No	Yes
3.	Do you limit your child's access to screens in their bedroom?	Yes	No
4.	Do you read with your child most days?	Yes	No
5.	Does your child play actively for at least one hour per day?	Yes	No
6.	Does your child sleep 9 to 11 hours per night?	Yes	No
7.	Is your child having problems with learning or concentrating in school?	No	Yes
8.	Is your child having problems with happiness or peer relationships (lack of friends, bullying)?	No	Yes
9.	Does your child have an IEP, 504 or other learning plan?	No	Yes
10.	Is your child showing any signs of puberty (breast development, hair in pubic areas or armpits, testicle enlargement)?	No	Yes

Nutrition

11.	Is your child eating 5 or more servings of fruits and vegetables daily?	Yes	No
12.	Does your child eat junk food more than 2-3 times a week? (Examples: candy, chips, cookies, sweet cereal, fast food.)	No	Yes
13.	Does your child drink juice, soda or other sweetened drinks more than 1-2 times per week?	No	Yes
14.	Are you worried about your child's weight?	No	Yes
15.	Does your child have regular, soft bowel movements (poop)?	Yes	No

Oral health

16.	Does your child see a dentist at least 2 times a year? (If so, skip to the next section.)	Yes	No

If not…

a. Has any caregiver had cavities/dental decay in the past year?	No	Yes	
b. Does your child drink something other than water from a cup continually and/or snack frequently throughout the day?	No	Yes	
c. Does your water contain fluoride or is your child on a fluoride supplement?	Yes	No	Not sure
d. Does your child get their teeth brushed twice daily?	Yes	No	

Social stressors

17. Are you having any family stress?	No	Yes	
18. Is there someone in your life that hurts you or your children?	No	Yes	
19. Within the past 12 months have you worried that your food would run out before you got money to buy more?	Never	Sometimes	Often

Tuberculosis

20. Is your child at risk for infection with tuberculosis? (Includes children born in Africa, Asia, Latin America, or eastern Europe; children who have stayed with family in one of those places for more than a week, or if exposed to anyone with active TB.)	No	Yes	Not sure

Safety checklist

Check all that apply.

	True	I have questions
21. We have rules about answering the door at home and Internet safety (with parental controls set).	☐	☐
22. My child rides in a forward-facing safety seat, in the back seat.	☐	☐
23. My child wears a helmet when biking, skating, skiing or snowboarding.	☐	☐
24. We apply sunscreen if out in the sun for longer than 15-30 minutes.	☐	☐
25. No one smokes or vapes around my child.	☐	☐
26. We have a home fire escape plan	☐	☐
27. Our gun is locked up, with the ammunition separate (or we don't have a gun).	☐	☐