Pre-visit questionnaire

## 9-10 years

## General

1. List any concerns you want to discuss today:       No       Yes         2. Does your child have more than 2 hours of screen time per day (smartphone, tablet, TV — not including time spent on schoolwork)?       No       Yes         3. Do you limit your child's access to screens in their bedroom?       Yes       No         4. Does your child play actively for at least one hour per day?       Yes       No         5. Does your child sleep 9 to 11 hours per night?       Yes       No         6. Does your child ave issues with anxiety, sadness, or anger?       No       Yes         7. Is your child eating 5 or more servings of fruits and vegetables daily?       Yes       No         8. Does your child dink juice, soda or other sweetened creal, fast food.)       No       Yes         9. Does your child dink juice, soda or other sweetened drinks more than 1-2 times per week?       No       Yes         10. Are you worried about your child's weight?       No       Yes         11. Does your child have a parent who has had a stroke or heart attack before age 55?       No       Yes         12. Does your child have a parent or sibling with high cholesterol or on cholesterol medication?       No       Yes         13. Does your child have a dentist at least 2 times a year?       Yes       No         14. What grade is your child in?       Yes       No         15. What school does your child att				
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	16		No	Yes
	17		No	Yes

		9-10 year Pre-visit question		
18. Does your child have an IEP, 504 or other learning plan?	No	Yes	Not sur	
Social stressors				
19. Are you having any family stress?	No	Yes		
20. Is there someone in your life that hurts you or your children?	No	Yes		
21. 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				
22. 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 sur	
Adolescence				
23. Is your child showing any signs of puberty (breast development, hair in pubic areas or armpits, testicle enlargement)?	No	Yes		
If appropriate for your child:				
24. Have they gotten their period?	No	Yes		
25. Do you or your child have concerns about menstruation (getting periods)?	No	Yes		
Safaty charlelist		ruo	have lestions	
Safety checklist Check all that apply.		90		
<b>26.</b> We have rules about answering the door at home and Internet safety (parental controls set).	VVILII			
27. My child uses a seatbelt in the car (or, they are under 4 foot 9 inches, s use a booster seat).	o they			
28. My child wears a helmet when biking, skating, skiing or snowboarding.				
<b>29</b> . We apply sunscreen if out in the sun for longer than 15-30 minutes.				
30. No one smokes or vapes around my child.				
31. We have working smoke/carbon monoxide detectors at home.				