Well child

Pre-visit questionnaire

9-10 years

General

1.	List any concerns you want to discuss today:		
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 have issues with anxiety, sadness, or anger?	No	Yes

Nutrition

7.	Is your child eating 5 or more servings of fruits and vegetables daily?	Yes	No
8.	Does your child eat junk food more than 2-3 times a week? (Examples: candy, chips, cookies, sweetened cereal, fast food.)	No	Yes
9.	Does your child drink 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

Oral health

13.	Does your child see a dentist at least 2 times a year?	Yes	No

School

14.	What grade is your child in?		
15.	What school does your child attend?		
16.	Is your child having problems with learning or concentrating in school?	No	Yes
17.	Is your child having problems with happiness or peer relationships (lack of friends, bullying)?	No	Yes

18. Does your child have an IEP, 504 or other learning plan?	No	Yes	Not sure

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 sure

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	

Safety checklist

Check all that apply.

	True	I have questions
26. We have rules about answering the door at home and Internet safety (with parental controls set).	☐	☐
27. My child uses a seatbelt in the car (or, they are under 4 foot 9 inches, so they use a booster seat).	☐	☐
28. My child wears a helmet when biking, skating, skiing or snowboarding.	☐	☐
29. 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.	☐	☐
32. Our gun is locked up, with the ammunition separate (or we don't have a gun).	☐	☐