4 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 concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES
6	Do you have any concerns about allergies?	NO	YES

Feeding/Nutrition

7	Does your child eat fruits or vegetables at every meal?	YES	NO
8	Do you feed your child mostly whole grains?	YES	NO
9	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
10	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
11	Does your child snack more than 2 times a day?	NO	YES
12	Does your child drink soda, juice, or other sweetened drinks more than once or twice per week?	NO	YES
13	Do you give your child any vitamins or supplements?	NO	YES
14	Are you worried about your child's weight?	NO	YES

Lipids

15	Does your child have parents or grandparents with stroke or heart attack before age 55?	NO	YES
16	Does your child have a parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

17 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
18 Does your child see a dentist at least twice a year?	YES	NO
19 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

20 Does your child have regular soft bowel movements (poop)?	YES	NO
21 Is your child potty trained during the day?	YES	NO

School

22 Is your child in preschool?	YES	NO
23 Do you have any concerns about learning or school behavior?	NO	YES

Activity / Exercise / Screen Time

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

Sleep

30 Do you have concerns about your child’s sleep?	NO	YES
31 Does your child snore more than a little?	NO	YES

Social Stressors

32 Do you feel you receive the support you need?	YES	NO	
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

Behavior

36 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
37 Do you praise your child when he/she is behaving well?	YES	NO
38 Do you give your child choices?	YES	NO

Development

39 Does your child talk well, using long meaningful sentences?	YES	NO
40 Can other people can fully understand what your child is saying?	YES	NO
41 Does your child know his/her full name, telephone number, and 911?	YES	NO
42 Does your child make up stories, fantasies, situations?	YES	NO
43 Can your child skip or hop on one foot 4-5 times?	YES	NO
44 Does your child know 4 or more colors?	YES	NO
45 Can your child count to 10?	YES	NO
46 Can your child stack 8 or more blocks?	YES	NO
47 Can your child draw a person with at least 3 body parts?	YES	NO
48 Can you child copy a cross?	YES	NO
49 Can your child dress him/herself without supervision?	YES	NO

Safety

50 Do you talk to your child about stranger safety?	YES	NO	
51 Does your child know that private parts are private?	YES	NO	
52 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
53 Does anyone smoke or vape around your child?	NO	YES	
54 If there is a gun in the home, is it locked in a safe with ammunition stored separately	N/A	NO	YES
55 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO	
56 Do you put sunscreen on your child when outside for a long time?	YES	NO	
57 Do you ever leave your child alone in the car, house, or yard?	NO	YES	
58 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
59 Do you have a home fire escape plan?	YES	NO	

Tuberculosis

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