5 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

Feeding/Nutrition

4	Does your child eat fruits or vegetables at every meal?	YES	NO
5	Do you feed your child mostly whole grains?	YES	NO
6	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
7	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
8	Does your child snack more than 2 times a day?	NO	YES
9	Does your child drink soda, juice, or other sweetened drinks more than once or twice per week?	NO	YES
10	Do you give your child any vitamins or supplements?	NO	YES
11	Are you worried about your child's weight?	NO	YES

Oral Health

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

Elimination

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

School

16	Is your child in school?	YES	NO
17	Do you have any concerns about your child's learning or school behavior?	NO	YES

Activity / Exercise / Screen Time

18 Does your child have more than 2 hours of screen time per day (TV, smartphones, tablets)?	NO	YES
19 Does your child have any screen time in his/her bedroom?	NO	YES
20 Do you read to your child every day?	YES	NO
21 Do you and your family do active and educational activities like walking, bicycling, swimming, going to libraries or going on nature walks?	YES	NO
22 Do you eat meals together as a family?	YES	NO
23 Does your child play actively for at least 1 hour every day?	YES	NO

Sleep

24 Do you have concerns about your child's sleep?	NO	YES
25 Does your child snore more than a little?	NO	YES

Social Stressors

26 Do you feel you receive the support you need?	YES	NO	
27 Have there been any major changes or stresses in your family recently?	NO	YES	
28 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
29 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

Behavior

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

Development

33 Does your child tell a story using long meaningful sentences?	YES	NO
34 Can other people fully understand what your child is saying?	YES	NO
35 Does your child know full name, telephone number, and 911?	YES	NO
36 Does your child make up imaginary stories, fantasies, situations?	YES	NO
37 Can your child skip or hop on one foot 4-5 times?	YES	NO

38 Does your child know 4 or more colors?	YES	NO
39 Can your child count to 10?	YES	NO
40 Can you child stack 8 or more blocks?	YES	NO
41 Can you child draw a person with a head, body, arms and legs?	YES	NO
42 Can your child draw a triangle?	YES	NO
43 Can your child dress himself/herself without supervision?	YES	NO

Safety

44 Do you talk to your child about stranger safety?	YES	NO	
45 Does your child know that private parts are private?	YES	NO	
46 Do you watch your child when he/she plays outside?	YES	NO	
47 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
48 Does anyone smoke or vape around your child?	NO	YES	
49 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO	
50 If there is a gun in the home, is it locked in a safe with ammunition stored separately	N/A	NO	YES
51 Do you put sunscreen on your child when outside for 15-30 minutes?	YES	NO	
52 Do you ever leave your child alone in the car, house, or yard?	NO	YES	
53 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
54 Do you have a home fire escape plan?	YES	NO	

Tuberculosis

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

Review of Systems

59 Do you have any concerns about your child's vision?	NO	YES
60 Do you have any concerns about your child's hearing?	NO	YES
61 Do you have concerns about your child's breathing?	NO	YES
62 Does your child complain about frequent tummy (abdominal) pain?	NO	YES
63 Does your child complain about frequent joint pain?	NO	YES
64 Does your child complain about headaches?	NO	YES
65 Does your child have any problems with his/her skin or rashes?	NO	YES