6 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	Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

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

Lipids

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

Oral Health

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

School

16 Is your child having any problems with progress in school or ability to learn?	NO	YES
17 Is your child having any problems with sitting all day or concentrating on schoolwork?	NO	YES
18 Is your child having any problems with getting along with teachers?	NO	YES
19 Is your child having any problems with happiness, self-esteem, self-confidence?	NO	YES
20 Is your child having any problems with peer relationships (lack of friends, bullying)?	NO	YES
21 Does your child have an IEP or other learning plan?	NO	YES

Activity / Exercise / Screen Time

22 Does your child have more than 2 hours of screen time per day (TV, smartphones, tablets)?	NO	YES
23 Does your child have any screen time in his/her bedroom?	NO	YES
24 Do you read to your child every day?	YES	NO
25 Do you and your family do active and educational activities like walking, bicycling, swimming, going to libraries or going on nature walks?	YES	NO
26 Do you eat meals together as a family?	YES	NO
27 Do you spend time alone with each of your children?	YES	NO
28 Does your child play actively for at least 1 hour ever day?	YES	NO
29 Does your child have a hard time falling asleep or staying asleep at night?	NO	YES
30 Is your child sleeping 9-11 hours at night?	YES	NO

Social Stressors

31 Do you feel you receive the support you need?	YES	NO	
32 Have there been any major changes or stresses in your family recently?	NO	YES	
33 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
34 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
35 Is there someone in your life that hurts you or your children?	NO	YES	

Safety

36 Do you have rules about internet safety? Do you have parental controls set?	YES	NO	
37 Do you have rules about answering the door and phone at home?	YES	NO	
38 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
39 Does anyone smoke or vape around your child?	NO	YES	
40 If there is a gun in the home, is it locked in a safe with ammunition stored separately	N/A	NO	YES
41 Do you put sunscreen on your child when outside for a long time?	YES	NO	
42 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
43 Does your child use a child safety seat or booster seat when in the car?	YES	NO	
44 Do you have a home fire escape plan?	YES	NO	

Tuberculosis

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

Review of Systems

49 Do you have any concerns about your child's eating habits, weight loss, or lack of energy?	NO	YES
50 Does your child have any sleep problems, including a lot of snoring?	NO	YES
51 Do you have concerns about your child's eyes or vision?	NO	YES
52 Does your child have recurrent (many) ear, sinus or throat infections, or nosebleeds?	NO	YES
53 Does your child have chest pain, shortness of breath, or irregular heartbeat?	NO	YES
54 Are you concerned about your child's lungs or breathing?	NO	YES
55 Does your child complain about abdominal (tummy) pain, vomiting, diarrhea, constipation?	NO	YES
56 Does your child have kidney or bladder problems, infections, blood in the urine?	NO	YES
57 Do you have concerns about your child's skin, hair, or nails?	NO	YES

58 Does your child complain about joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
59 Do your child have recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
60 Does your child have anxiety, mood changes, sadness, nervous problems?	NO	YES
61 Does your child have excessive thirst or increased urination?	NO	YES
62 Does your child have easy bruising, swollen glands, or look pale?	NO	YES
63 Is your child showing any signs of puberty (breast development, hair in pubic areas or armpits, testicle enlargement)?	NO	YES