9-10 Year Questionnaire

History
Do you have any concerns about your child?
Yes No
Does your child have any special health care needs?
Yes No
Has your child seen another doctor, been to the hospital, emergency room or urgent care since your last visit?
Yes No
Has your child had any procedures or tests done since their last visit?
Yes No
Household
How many people (not including this child) are living in this child's home? ___________________
If this child is not living with both biological parents, what is living situation?
____
Social History
Have there been any major changes for your child or in your family lately?
Yes No
Does your child live with anyone who smokes or spend time in any places where people smoke?
____Does anyone smoke in the car your child travels in?
Yes No
Anemia Risk Assessment
Has your child ever been diagnosed with iron deficiency anemia?
Yes No
Do you ever have trouble getting food on the table?
Yes No
Is your child on a strict vegetarian diet?
Yes No
Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?
Yes No

Tuberculosis Risk Assessment
Has your child been exposed to someone with tuberculosis?
Yes No
Has a family member or contact had a positive tuberculin skin test?
Yes No
Was your child born in a country with a high risk of tuberculosis (countries other than of the US, Canada, Australia, New Zealand or Western Europe)?

Yes No
Has your child traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?
Yes No
Is your child infected with HIV?
Yes No
Dyslipidemia Risk Assessment
Has this child's parents or grandparents had a stroke or heart problem before the age of 55?
Yes No
Does this child have a parent or sibling that has high cholesterol (total cholesterol of 240 or higher) or taking cholesterol medication?
Yes No
Nutrition
How many servings of dairy products does your child have per day? For example, yogurt and cheese.
Less than 2 2-3 more than 3
How many servings of vegetables does your child have per day?
Less than 3 3-5 more than 5
How many servings of fruits does your child have per day?
Less than 2 2-4 more than 4
How many servings of whole grains does your child have per day?
Less than 6 6-11 more than 11
How many servings of protein does your child have per day? For example, meat, eggs, beans, tofu, etc.
Less than 2 2-3 more than 3
How many servings of junk food does your child have per day? For example, chips, candy, cookies, cakes, etc.
____
How often does your child have a fast food meal?
More than 1 meal per day
1 meal per day
4-6 meals per day
1-3 meals per day
6-11 meals per year
1-5 meals per year
How many ounces (oz) of milk does your child drink per day?______
How many ounces (oz) of juice does your child drink per day?________
How many ounces (oz) of soda or drink mixes like Kool-Aid does your child drink per day?____
Does your child take vitamins or supplements?
Yes No
Is your child on a strict vegetarian diet?
Yes No
Does your child eat breakfast every day?
Yes No
Does your child watch TV while eating?
Yes No
Do you have concerns about your child's weight?
Yes No
How often do you eat together as a family?__________________________________
Physical Activity

How many hours a day does your child spend being physically active?______________
Is your family physically active together?
Yes No
How many hours a day does your child spend watching TV or other electronic device screen? For example, computer, tablet, game console?______________
Sleep
How many hours does your child sleep per day?________
Does your child have problems with sleeping?
Yes No
Oral Health
How often are your child's teeth brushed?_____________
How often does your child see the dentist? _________________
Is your child drinking water that is fluoridated?
Yes No
Has your child had fluoride varnish applied to their teeth in the last 6 months?
Yes No
Does your child snack frequently?
Yes No
Does your child continually drink from a sippy cup throughout the day?
Yes No
Does your child wear a mouth guard while playing sports?
Yes No
Is your child eligible for Medicaid?
Yes No
Have you, the parent or primary caregiver, had any cavities in the last 12 months?
Yes No
Vision
Do you have concerns about the way your child sees?
Yes No
Does your child squint often?
Yes No
Has your child ever failed school vision screening test?
Yes No
Hearing
Do you have concerns about the way your child hears?
Yes No
Do you have concerns about the way your child speaks?
Yes No
Does your child have difficulty hearing over a noisy background or over phone?
Yes No
School
Which school is your child attending?_____________________
Does your child participate in special education services?
Yes No
How does your child feel about school?____

Do you have concerns about your child's school performance?
Yes No

Do you have concerns about your child's behavior?
Yes No
Do you have concerns about your child's attention?
Yes No
Do you have concerns about how your child interacts with others?
Yes No
Do you have concerns about your child's ability to do homework?
Yes No
Does your child have a routine and a place to do homework?
Yes No
Do you or your child's teacher have any other concerns?
Yes No
Who provides your child's after school care?____
Do you show interest in your child's school and activities?
Yes No
Do you have concerns your child is being bullied or teased?
Yes No

Behavior

Is your child overall a happy person?
Yes No
Do you encourage your child to make good decisions?
Yes No
Does your child do simple chores?
Yes No
Is youre child having problems interacting with you, other caregivers or siblings?
____
Do you use disciple to teach your child good behaviors and not as a way to punish?
Yes No
Do you teach your child to use words instead of violent behaviors?
Yes No
Has your child been getting into fights on the playground or other places?
Yes No

Safety

Does your child know what to do in an emergency if you are not there?
Yes No

Do you have a list of emergency numbers that are easy to find?
Yes No
Are there working smoke detectors in the house?
Yes No
Are there working carbon monoxide detectors in the house?
Yes No
Do you have a fire escape plan?
Yes No
Do you feel safe in your home?
Yes No
Do you feel safe in your community?
Yes No

Do you know how or where to get help if you don't feel safe in your home?
Yes No
In places where this child spends time, are medications, chemicals and insecticides kept locked up?
Yes No
Is the phone number for Poison Control easily located?
Yes No
When your child rides in a car, do you use a car seat or booster seat?_________________
Where in the car is the car seat or booster seat located?___________________
Does your child know street safety like stopping at a curb, looking both ways and never crossing the street without an adult?
Yes No
Is there a swimming pool, pond, or lake near your home or where your child spends time?
Yes No

Does your child know how to swim?
Yes No
Does your child wear sunscreen or sun protective clothing when outside?
Yes No
Does your child wear a helmet while biking, riding a scooter, skating, skateboarding, skiing, snowboarding, or horseback riding?
Yes No
Are there any guns in your home or where your child spends time?
Do you know your child's friends and their families?
Yes No
Does your child know it is never ok for an adult to tell a child to keep secrets from their parents?
Yes No
Does your child know it is never ok for an older child or adult to ask to see their private parts?
Yes No
Are there safety filters installed on all the computers and computer devices that your child uses?
Yes No
Do you regularly check your child's internet history?
Yes No
Is the computer that your child uses in a place you can easily see?
Yes No
Do you talk to your child about alcohol and the importance of not using it?
Yes No
Do you talk to your child about cigarettes and other tobacco products and the importance of not using it?
Yes No
Do you talk to your child about street drugs and the importance of not using it?
Yes No
Are you comfortable answering your child's questions about their body?
Yes No
Do you answer your child's questions about sex?
Yes No
Do you discuss with your child the importance of waiting to have sex?
Yes No