## 9-10 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.

2. Does child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?  Feeding/Nutrition  3. Child has fruits or vegetables at every meal? YES NO 4. Giving your child mostly whole grains? YES NO 5. Is your child drinking milk? YES NO a. What type of milk? D. How much milk per day?  6. Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?  7. Child drinks soda, juice, or other sweetened beverages? NO YES Are you giving any vitamins or supplements? YES NO YES 10. Parents/grandparents with stroke/heart attack before 55? NO YES 10. Parent with high cholesterol or on cholesterol medication? NO YES NO 12. Brushing teeth twice a day and flossing once a day? YES NO 13. Sees a dentist at least twice per year? YES NO 4. Does your child's water contain fluoride or is your child on a fluoride supplement?  School  15. Problems with progress in school or ability to learn? NO YES NO YES Problems with siting still or concentrating on schoolwork? NO YES 18. Problems with siting still or concentrating on schoolwork? NO YES 19. Problems with happiness, self esteem, self-confidence? NO YES 19. Problems with happiness, self esteem, self-confidence? NO YES 19. Problems with peer relationships (lack of friends, NO YES Dullying)?  Activity/Exercise/Screen time  21. Does your child have more than 2 hours of screen time per NO YES day (TV, computer, video games)?	1.	Do you have any concerns about your child's health?	NO	YES
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<ul> <li>18. Problems with happiness, self esteem, self-confidence? NO YES 19. Problems with irritability, temper, outbursts, excessive NO YES anger?</li> <li>20. Problems with peer relationships (lack of friends, bullying)?</li> <li>Activity/Exercise/Screen time</li> <li>21. Does your child have more than 2 hours of screen time per day (TV, computer, video games)?</li> <li>22. Is there a TV, computer, or video game system in your child's bedroom?</li> <li>23. Plays actively at least one hour per day? YES NO YES wimming, or dancing?</li> <li>25. Do you do educational activities as a family, such as go to museums, zoos, or libraries?</li> </ul>				
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<b>25.</b> Do you do educational activities as a family, such as go to YES NO museums, zoos, or libraries?		. Do you encourage activities such as walking, bicycling,		
	25	. Do you do educational activities as a family, such as go to	YES	NO
<b>20.</b> Do you eat meals together as a family?	20		VEC	NO
,				
<ul><li>27. Do you spend time alone with each of your children?</li><li>28. Do you spend time alone with your partner?</li><li>YES</li><li>NO</li></ul>				

Social Stressors 29. Are you able to take some time for yourself?	YES	NO
30. Is your partner hurting you or your children?	NO	YES
31. Any major changes or stresses in your family recently?	NO	YES
32. Do you ever fear your family will go hungry?	NO	YES
22. Do you ever rear your farmly will go nurigry:	INO	ILO
afety	\/F0	NO
3. Have rules about internet safety? Parental controls set?	YES	NO
4. Have rules about being home alone (answering the door and phone)?	YES	NO
5. Child wears a helmet when biking, skating, skiing or snowboarding?	YES	NO
6. Is child exposed to anyone who smokes?	NO	YES
7. Is there a gun in the home? <ul> <li>a. Is it locked or in a safe?</li> </ul>	NO	YES
8. Applying sunscreen when outside for a long time?	YES	NO
9. Child uses a seatbelt in the car? Sits in the back seat?	YES	NO
O. House has working smoke detectors and carbon monoxide detectors?	YES	NO
1. Do you have a home fire escape plan?	YES	NO
uberculosis		
2. Has a family member or contact had tuberculosis disease?	NO	YES
3. Has a family member had a positive TB skin test (PPD)?	NO	YES
, , ,		
14. Was your child born in a high-risk country (countries other	NO	YES
14. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
14. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?		
<ul><li>14. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?</li><li>15. Has your child traveled to a high-risk country for more than a week?</li></ul>	NO	YES
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<ul> <li>4. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?</li> <li>5. Has your child traveled to a high-risk country for more than a week?</li> <li>eview of Systems</li> <li>any Concerns about</li> <li>6. Eating habits, weight loss, or lack of energy?</li> <li>7. Sleep problems, including excessive snoring?</li> </ul>	NO NO NO	YES YES YES
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<ul> <li>44. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?</li> <li>45. Has your child traveled to a high-risk country for more than a week?</li> <li>46. Eating habits, weight loss, or lack of energy?</li> <li>47. Sleep problems, including excessive snoring?</li> <li>48. Eye redness, excessive tearing, or discharge?</li> <li>49. Recurrent ear, sinus or throat infections, nosebleeds?</li> <li>40. Chest pain, shortness of breath, or irregular heartbeat?</li> <li>41. Frequent colds, cough, wheezing, recurrent lung infections?</li> <li>42. Abdominal pain, vomiting, diarrhea, constipation?</li> <li>43. Kidney or bladder problems, infections, blood in the urine?</li> <li>44. Birthmarks, skin rashes, itching, nail or hair problems?</li> <li>45. Joint pain, stiffness, swelling, muscle pain or weakness?</li> <li>46. Recurrent headaches, dizziness, tics, weakness, seizures?</li> <li>47. Mood changes, sadness, nervous problems?</li> </ul>	NO N	YES
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<ul> <li>14. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?</li> <li>15. Has your child traveled to a high-risk country for more than a week?</li> <li>16. Eating habits, weight loss, or lack of energy?</li> <li>17. Sleep problems, including excessive snoring?</li> <li>18. Eye redness, excessive tearing, or discharge?</li> <li>19. Recurrent ear, sinus or throat infections, nosebleeds?</li> <li>10. Chest pain, shortness of breath, or irregular heartbeat?</li> <li>11. Frequent colds, cough, wheezing, recurrent lung infections?</li> <li>12. Abdominal pain, vomiting, diarrhea, constipation?</li> <li>13. Kidney or bladder problems, infections, blood in the urine?</li> <li>14. Birthmarks, skin rashes, itching, nail or hair problems?</li> <li>15. Joint pain, stiffness, swelling, muscle pain or weakness?</li> <li>16. Recurrent headaches, dizziness, tics, weakness, seizures?</li> <li>17. Mood changes, sadness, nervous problems?</li> <li>18. Excessive thirst or hunger, increased urination?</li> <li>19. Paleness, anemia, easy bruising, swollen glands?</li> </ul>	NO N	YES
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<ul> <li>44. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?</li> <li>45. Has your child traveled to a high-risk country for more than a week?</li> <li>Review of Systems</li> <li>Any Concerns about</li> <li>46. Eating habits, weight loss, or lack of energy?</li> <li>47. Sleep problems, including excessive snoring?</li> <li>48. Eye redness, excessive tearing, or discharge?</li> <li>49. Recurrent ear, sinus or throat infections, nosebleeds?</li> <li>50. Chest pain, shortness of breath, or irregular heartbeat?</li> <li>51. Frequent colds, cough, wheezing, recurrent lung infections?</li> <li>52. Abdominal pain, vomiting, diarrhea, constipation?</li> <li>53. Kidney or bladder problems, infections, blood in the urine?</li> <li>54. Birthmarks, skin rashes, itching, nail or hair problems?</li> <li>55. Joint pain, stiffness, swelling, muscle pain or weakness?</li> <li>56. Recurrent headaches, dizziness, tics, weakness,</li> </ul>	NO N	YES