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.

General Health			
1.	Do you have any concerns about your child's health?	NO	YES
2.	Does child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?	NO	YES
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?		
	b. How much milk per day?		
6.	Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
7.	Child drinks soda, juice, or other sweetened beverages?	NO	YES
8.	Are you giving any vitamins or supplements?	YES	NO
Lipids			
9.	Parents/grandparents with stroke/heart attack before 55?	NO	YES
10.	Parent with high cholesterol or on cholesterol medication?	NO	YES
Oral Health			
11.	Are cavities a problem for you or anyone in your family?	NO	YES
12.	Brushing teeth twice a day and flossing once a day?	YES	NO
13.	Sees a dentist at least twice per year?	YES	NO
14.	Does your child's water contain fluoride or is your child on a fluoride supplement?	YES	NO
School			
15.	Problems with progress in school or ability to learn?	NO	YES
16.	Problems with siting still or concentrating on schoolwork?	NO	YES
17.	Problems with ability to get along with teachers?	NO	YES
18.	Problems with happiness, self esteem, self-confidence?	NO	YES
19.	Problems with irritability, temper, outbursts, excessive anger?	NO	YES
20.	Problems with peer relationships (lack of friends, bullying)?	NO	YES
Activity/Exercise/Screen time			
21.	Does your child have more than 2 hours of screen time per day (TV, computer, video games)?	NO	YES
22.	Is there a TV, computer, or video game system in your child's bedroom?	NO	YES
23.	Plays actively at least one hour per day?	YES	NO
24.	Do you encourage activities such as walking, bicycling, swimming, or dancing?	YES	NO
25.	Do you do educational activities as a family, such as go to museums, zoos, or libraries?	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.	Do you spend time alone with your partner?	YES	NO

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

Safety		
33. Have rules about internet safety? Parental controls set?	YES	NO
34. Have rules about being home alone (answering the door and phone)?	YES	NO
35. Child wears a helmet when biking, skating, skiing or snowboarding?	YES	NO
36. Is child exposed to anyone who smokes?	NO	YES
37. Is there a gun in the home? a. Is it locked or in a safe?	NO	YES
38. Applying sunscreen when outside for a long time?	YES	NO
39. Child uses a seatbelt in the car? Sits in the back seat?	YES	NO
40. House has working smoke detectors and carbon monoxide detectors?	YES	NO
41. Do you have a home fire escape plan?	YES	NO

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

Review of Systems		
*Any **Concerns** about...*		
46. Eating habits, weight loss, or lack of energy?	NO	YES
47. Sleep problems, including excessive snoring?	NO	YES
48. Eye redness, excessive tearing, or discharge?	NO	YES
49. Recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
50. Chest pain, shortness of breath, or irregular heartbeat?	NO	YES
51. Frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
52. Abdominal pain, vomiting, diarrhea, constipation?	NO	YES
53. Kidney or bladder problems, infections, blood in the urine?	NO	YES
54. Birthmarks, skin rashes, itching, nail or hair problems?	NO	YES
55. Joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
56. Recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
57. Mood changes, sadness, nervous problems?	NO	YES
58. Excessive thirst or hunger, increased urination?	NO	YES
59. Paleness, anemia, easy bruising, swollen glands?	NO	YES
60. Puberty?	NO	YES
For girls:		
a. Has she gotten her period?	NO	YES
b. Problems or questions about menstruation?	NO	YES