3 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

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

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

Oral Health

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

Elimination

18 Does your child have regular soft bowel movements (poop)?	YES	NO
19 Is your child toilet (potty) trained?	YES	NO

School

20 Is your child in preschool or childcare?	YES	NO

Activity / Exercise / Screen Time

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

Social Stressors

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

Behavior

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

Development

35 Does your child put 2 or 3 sentences together?	YES	NO
36 Can people usually understand what your child is saying, even non-family members?	YES	NO
37 Can your child count to 5 or more?	YES	NO
38 Does your child know 2 or more colors?	YES	NO
39 Does your child pretend play, like using a telephone or playing house?	YES	NO
40 Can your child draw a person with at least two body parts?	YES	NO
41 Does your child walk up and down stairs alternating feet? (one foot on each step)	YES	NO
42 Does your child feed himself/herself well using a fork and spoon?	YES	NO
43 Can your child dress or undress with only a little help?	YES	NO
44 Can your child throw a ball overhand?	YES	NO
45 Can your child balance on one foot?	YES	NO
46 Is your child toilet (potty) trained during the day?	YES	NO
47 Can your child name a friend?	YES	NO

Safety

48 Do you watch your child when he/she plays outside?	YES	NO	
49 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO	
50 Does your child wear a helmet when riding a scooter, tricycle, or bicycle?	YES	NO	
51 Does anyone smoke or vape around your child?	NO	YES	
52 If there is a gun in the home, is it locked in a safe with ammunition stored separately	N/A	NO	YES
53 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO	
54 Do you put sunscreen on your child when outside for a long time?	YES	NO	
55 Do you have the number for Poison Control?	YES	NO	
56 If there is a swimming pool, pond, or lake near your home, is it secured so that your child cannot access it?	N/A	NO	YES

Tuberculosis

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