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 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	Is your child brushing their teeth with fluoridated toothpaste twice a day and flossing once a 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 still or concentrating in school?	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 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 ever day?	YES	NO
27 Does your child have a hard time falling asleep or staying asleep at night?	NO	YES
28 Is your child sleeping 9-11 hours at night?	YES	NO

Social Stressors

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

Safety

34 Do you have rules about internet safety? Do you have parental controls set?	YES	NO	
35 Do you have rules about answering the door and phone at home?	YES	NO	

36 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
37 Does anyone smoke or vape around your child?	NO	YES	
38 If there is a gun in the home, is it locked in a safe with ammunition stored separately	N/A	NO	YES
39 Do you put sunscreen on your child when outside for a long time?	YES	NO	
40 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
41 Does your child use a seatbelt in the car or booster seat (if under 4 feet 9 inches tall)?	YES	NO	
42 Do you have a home fire escape plan?	YES	NO	

Tuberculosis

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

Review of Systems

47 Do you have any concerns about your child's eating habits, weight loss, or lack of energy?	NO	YES
48 Does your child have any sleep problems, including a lot of snoring?	NO	YES
49 Do you have concerns about your child's eyes or vision?	NO	YES
50 Does your child have recurrent (many) ear, sinus or throat infections, or nosebleeds?	NO	YES
51 Does your child have chest pain, shortness of breath, or irregular heartbeat?	NO	YES
52 Does your child have frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
53 Does your child complain about abdominal (tummy) pain, vomiting, diarrhea, constipation?	NO	YES
54 Does your child have kidney or bladder problems, infections, blood in the urine?	NO	YES
55 Do you have concerns about your child's skin, hair, or nails?	NO	YES
56 Does your child complain about joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
57 Do your child have recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES

58 Does your child have anxiety, mood changes, sadness, nervous problems or issues with anger/temper?	NO	YES
59 Does your child have excessive thirst or increased urination?	NO	YES
60 Does your child have easy bruising, swollen glands, or look pale?	NO	YES
61 Is your child showing any signs of puberty (breast development, hair in pubic areas or armpits, testicle enlargement)?	NO	YES

For girls:

a. Has she gotten her period?	NO	YES
b. Do you or your child have any problems with or questions about menstruation (getting your period)?	NO	YES