4 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	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, nurse practitioner or physician's assistant (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
6	Do you have any concerns about allergies?	NO	YES

Feeding/Nutrition

7	Is your child eating 5 servings of fruits and vegetables daily?	YES	NO
8	When your child has grains (cereal, bread, pasta, crackers, waffles, rice, etc.), are they mostly whole grains?	YES	NO
9	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
10	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than 2-3 times per week?	NO	YES
11	Does your child snack more than 1-2 times a day on foods other than fruits and vegetables?	NO	YES
12	Does your child drink soda, juice, or other sweetened drinks more than once or twice per week?	NO	YES
13	Do you give your child any vitamins or supplements?	NO	YES
14	Are you worried about your child's weight?	NO	YES

Lipids

15	Does your child have a parent who has had a stroke or heart attack before age 55?	NO	YES
16	Does your child have a parent or sibling with high cholesterol?	NO	YES

Oral Health

17 Does your child see a dentist at least twice a year?	YES	NO

Elimination

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

School

20 Is your child in preschool?	YES	NO
21 Do you have any concerns about learning or school behavior?	NO	YES

Activity / Exercise / Screen Time

22 Does your child have more than 1 hour 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 read to your child every day?	YES	NO
25 Do you and your family do active and educational activities like walking, bicycling, swimming, going to libraries or going on nature walks?	YES	NO
26 Do you eat meals together as a family?	YES	NO
27 Does your child play actively for at least 1 hour every day?	YES	NO

Sleep

28 Do you have concerns about your child's sleep?	NO	YES
29 Does your child snore more than a little?	NO	YES
30 Does your child sleep 10 to 13 hours/day (nighttime plus naps)?	YES	NO

Social Stressors

31 Have there been any major changes or stresses in your family recently?	NO	YES	
32 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
33 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
34 Do you always feel safe in your home?	YES	NO	

Behavior

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

Development

38 Does your child talk well, using long meaningful sentences?	YES	NO
39 Can other people fully understand what your child is saying?	YES	NO
40 Does your child make up stories, fantasies, situations?	YES	NO
41 Can your child skip or hop on one foot 4-5 times?	YES	NO
42 Does your child know 4 or more colors?	YES	NO
43 Can your child count to 10?	YES	NO
44 Can your child stack 8 or more blocks?	YES	NO
45 Can your child draw a person with at least 3 body parts?	YES	NO
46 Can you child copy a cross?	YES	NO
47 Can your child dress him/herself without supervision?	YES	NO

Safety

48 Do you talk to your child about stranger safety?	YES	NO	
49 Does your child know that private parts are private?	YES	NO	
50 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
51 Does anyone smoke or vape around your child?	NO	YES	
52 Is there a gun in the home?	NO	YES	
a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY
53 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO	
54 If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15 to 30 minutes?	YES	NO	DOESN'T APPLY
55 Do you ever leave your child alone in the car, house, or yard?	NO	YES	
56 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
57 Do you have a home fire escape plan?	YES	NO	

Tuberculosis

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