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 your child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, 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 Is your child drinking milk?	YES	NO
a What kind of milk?		
b How much milk per day?		
6 Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods?	NO	YES
7 Does your child drink soda, pop, juice, or other sweetened drinks?	NO	YES
8 Do you give your child any vitamins or supplements?	NO	YES
9 Are you worried about your child's weight?	NO	YES

Lipids

10 Does your child have parents or grandparents who had a stroke or heart attack before age 55?	NO	YES
11 Does your child have a parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

12 Are cavities a problem for you or anyone in your family?	NO	YES
13 Is your child brushing teeth with fluoridated toothpaste twice a day and flossing once a day?	YES	NO
14 Does your child see dentist at least twice per 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 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 irritability, temper, outbursts, excessive anger?	NO	YES
21 Is your child having any problems with peer relationships (lack of friends, bullying)?	NO	YES
22 Does your child have an IEP or other learning plan?	NO	YES

Activity/Exercise/Screen time

23 Does your child have more than 2 hours of screen time per day (TV, smartphones, tablets)?	NO	YES
24 Does your child have any screen time in his/her bedroom?	NO	YES
25 Do you do family activities like walking, bicycling, swimming, or dancing?	YES	NO
26 Do you do educational activities as a family, like go to libraries, museums, zoos, or on nature walks?	YES	NO
27 Do you eat meals together as a family?	YES	NO
28 Do you spend time alone with each of your children?	YES	NO

Social Stressors

29 Do you feel that 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 Is there a gun in the home?	NO	YES
a If yes, is it locked or in a safe and is the ammunition stored separately?	YES	NO
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

Any Concerns about….

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 of 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 Does your child have recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
58 Does your child have anxiety, mood changes, sadness, nervous problems?	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 the pubic area or armpits, testical enlargment)	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