5 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 (acupuncturist, herbalist, naturopath)?	NO	YES

Feeding/Nutrition

4	Does your child eat fruits or vegetables at every meal?	YES	NO
5	Do you feed your child mostly whole grains?	YES	NO
6	Is your child drinking milk?	YES	NO
	a What kind of milk?		
	b How much milk per day?		
7	Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods?	NO	YES
8	Does your child drink juice or other sweetened drinks?	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 who had a 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 Are cavities a problem for you or anyone in your family?	NO	YES
14 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
15 Does your child see a dentist twice a year?	YES	NO
16 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

17 Does your child have regular soft bowel movements (poop)?	YES	NO

School

18 Is your child in school?	YES	NO
19 Do you have any concerns about your child's learning or school behavior?	NO	YES

Activity/Exercise/Screen time

20 Does your child have more than 2 hours of screen time per day (TV, smartphones, tablets)?	NO	YES
21 Does your child have any screen time in his/her bedroom?	NO	YES
22 Do you read to your child every day?	YES	NO
23 Do you do family activities like walking, bicycling, swimming, or dancing?	YES	NO
24 Do you do educational activities as a family, like go to libraries, museums, zoos, or on nature walks?	YES	NO
25 Do you eat meals together as a family?	YES	NO
26 Do you spend time alone with each of your children?	YES	NO
27 Does your child play actively at least 1 hour every day?	YES	NO

Sleep

28 Do you have any concerns about your child's sleep?	NO	YES
29 Does your child snore more than a little?	NO	YES

Social Stressors

30 Do you feel that you receive the support you need?	YES	NO	
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

Behavior

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

Development

37 Does your child talk well, using long meaningful sentences?	YES	NO
38 Does your child tell simple stories and nursery rhymes?	YES	NO
39 Can other people fully understand what your child is saying?	YES	NO
40 Does your child know full name, telephone number, and 911?	YES	NO
41 Does your child make up imaginary stories, fantasies, situations?	YES	NO
42 Can your child skip or hops on one foot 4-5 times?	YES	NO
43 Does your child know 4 or more colors?	YES	NO
44 Can your child count to 10?	YES	NO
45 Can your child stack 8 or more blocks?	YES	NO
46 Can your child draw a person with head, body, arms, and legs?	YES	NO
47 Can your child draw a square?	YES	NO
48 Can your child dress him/herself without supervision?	YES	NO

Safety

49 Do you talk to your child about stranger safety?	YES	NO
50 Does your child know that private parts are private?	YES	NO
51 Do you watch your child when he/she plays outside?	YES	NO
52 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO
53 Does anyone smoke or vape around your child	NO	YES
54 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO
55 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
56 Do you put sunscreen on your child when outside for a long time?	YES	NO
57 Do you ever leave your child alone in the car, house, or yard?	NO	YES
58 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO
59 Do you have a home fire escape plan?	YES	NO

Tuberculosis

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

Review of Systems

Any Concerns about…

64	Do you have any concerns about your child's vision?	NO	YES
65	Do you have any concerns about your child's hearing?	NO	YES
66	Does your child wheeze when breathing?	NO	YES
67	Does your child complain about frequent tummy (abdominal) pain?	NO	YES
68	Does your child complain about frequent joint pains?	NO	YES
69	Does your child complain about Headaches?	NO	YES
70	Does your child have any problems with his/her skin or rashes?	NO	YES