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 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 at least 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
18 Have you started toilet (potty) training?	YES	NO

School

19 Is your child in preschool or childcare?	YES	NO

Activity/Exercise/Screen time

20 Does your child have more than 1 hour 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

Social Stressors

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

Behavior

32 Does your child have a lot of tantrums?	NO	YES
33 Do you have any questions about how to discipline your child?	NO	YES
34 Do you praise your child when he/she is behaving well?	YES	NO
35 Do you give your child choices?	YES	NO

Development

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

Safety

49 Do you watch your child when he/she plays outside?	YES	NO
50 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO
51 Does your child wear a helmet when riding a scooter, tricycle, or bicycle?	YES	NO
52 Does anyone smoke or vape around your child	NO	YES
53 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
54 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO
55 Do you put sunscreen on your child when outside for a long time?	YES	NO
56 Do you have the number for Poison Control?	YES	NO
57 Is there a swimming pool, pond, or lake near your home?	NO	YES

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 week?	NO	YES

Review of Systems

62 Do you have any concerns about your child's hearing?	NO	YES
63 Do you have any concerns about your child's vision?	NO	YES