Parental Concerns for Well Visits Age 4-8 years

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Child's Name: _____ Date: _____

Child's Age: _____ Date of birth: _____

Diet/Growth:

1. My child eats healthy foods: □ Yes □ No
   a. I wish my child ate more _____ I wish my child ate less _____
   b. We eat at least one meal per day together as a family: □ Yes □ No
2. I feel that my child is: □ Too heavy □ Too light □ Just right I feel that my child is: □ Too tall □ Too short □ Just right
3. My child takes a vitamin: □ Yes □ No
   a. Which vitamin: _____ □ Gummy □ Chewable
   b. What time of day: _____ I wonder whether my child needs to take a vitamin: □ Yes □ No
4. My child drinks milk: □ Yes □ No
   a. _____ ounces per day
   b. □ Whole □ 2% □ 1% □ Skim □ Almond □ Soy □ Other _____
5. My child has a family history of high cholesterol: □ Yes □ No
   a. Who has high cholesterol? □ Mom □ Dad □ Aunt/Uncle □ Grandparent
   b. This is being treated with: □ Dietary changes □ Exercise □ Medications □ Not treated □Unknown
6. My child gets exercise: □ Yes □ No
   a. At least 30 minutes a day? □ Yes □ No
   b. What sport or activity? _____

Elimination:

1. My child has urine accidents: □ Yes □ No
   a. This happens: □ Daytime □ Night-time This bothers: □ My child □ My spouse □ No one is bothered
   b. There is a family history of childhood bed-wetting in: □ Mom □ Dad □ None
2. My child has stool daily: □ Yes □ No □ Don't know
   a. My child's stool is: □ Soft □ Hard □ Don't know My child has pain with pooping: □ Yes □ No
   b. My child has poop accidents: □ Yes □ No

Safety:

1. My child can swim: □ Yes □ No We have a pool: □ Yes □ No We have a pool fence: □ Yes □ No
2. There is a gun in my home: □Yes □No It is stored (check all that apply) □Locked □Unlocked □Loaded □Unloaded □n/a
3. In the car, my child uses a booster seat or wears a seat belt? □ Yes □ No
4. On anything with wheels, my child wears a helmet? □Yes □ No

Sleep:

1. My child sleeps through the night: □ Yes □ No
   a. My child gets how many hours of uninterrupted sleep: _____ hours My child goes to sleep easily: □ Yes □ No
   b. My child snores: □ Yes □ No
   c. My child has nightmares/sleepwalking/sleep disturbance: □ Yes □ No
   d. My child looks at screens (TV, phone, computer) in the hour before bedtime: □ Yes □ No

Behavior:

1. My child is well behaved/minds: □ Yes □ No
   a. My child has trouble minding at: □ School □ Home □ Both
   b. I am concerned about my child's behavior: □ Yes □ No
2. I am proud of my child: □ Yes □ No

Learning:

1. My child attends school: □ Yes □ No Where: _____ Grade: _____
2. My child gets good grades: □ Yes □ No Typical marks/grades: □ A's □ B's □ C's □ D's □ F's □ Not graded
3. My child's learning is: □ Advanced □ On grade Level □ Behind
4. My child can see well and hear well and speak clearly: □ Yes □ No
5. I worry that my child has a learning problem: □ Yes □ No

Other worries I have: _____ **Parent Signature**: _____