

Parental Concerns for Well Visits Age 9-14 years

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Child's Name: _____

Date: _____

Child's Age: _____

Date of birth: _____

Diet/Growth:

- My child eats healthy foods: Yes No
 - I wish my child ate more _____
 - I wish my child ate less _____
- I feel that my child is: Too heavy Too light Just right
 - I think my child feels that his/her weight is: Too heavy Too light Just right
- I feel that my child is: Too tall Too short Just right
 - I think my child feels that his/her height is : Too tall Too short Just right
- My child has started puberty: Yes No Unsure
 - I think my child is happy with the appearance of his/her skin: Yes No Unsure
- My child takes a vitamin: Yes No
 - Which vitamin: _____ Gummy Chewable Pill
- My child drinks milk: Yes No
 - _____ ounces per day
 - Whole 2% 1% Skim Almond Soy Other _____
- My child has a family history of high cholesterol: Yes No
 - Who has high cholesterol? Mom Dad Aunt/Uncle Grandparent
 - This is being treated with: Dietary changes Exercise Medications Not treated Unsure
- My child gets exercise: Yes No
 - At least 30 minutes a day? Yes No
 - What sport or activity? _____
 - My child complains of dizziness, shortness of breath, fatigue or chest pain during exercise? Yes No
 - Is there a family history of cardiac/unexplained death before 50? Yes No Who? _____

Elimination:

- My child has urine accidents: Yes No
 - This happens: Daytime Night-time
 - This bothers: My child My spouse No one is bothered
- My child has stool daily: Yes No Don't know
 - My child's stool is: Soft Hard Don't know

Sleep:

- My child sleeps through the night: Yes No
 - My child gets how many hours of uninterrupted sleep at night: _____ hours
 - My child snores: Yes No
 - My child has nightmares/sleepwalking/insomnia/sleep disturbance: Yes No
 - My child looks at screens in the hour before bedtime: Yes No

Behavior:

- My child is well behaved/minds: Yes No
 - My child has trouble minding at: School Home Both
 - I am concerned about my child's behavior: Yes No
- I am proud of my child: Yes No

Learning:

- My child attends school: Yes No Where: _____ Grade: _____
- My child's typical marks/grades: A's B's C's D's F's Not graded
- My child's learning is: Advanced On grade level Behind
- My child can see well and hear well and speak clearly: Yes No
- I worry that my child has a learning problem: Yes No

Other worries I have: _____ Parent Signature: _____