



PATIENT NAME _____ AGE _____ SEX _____ EXAM. DATE _____

Welcome to you and your child.

(Please explain right-hand column answers here.)

- | | | |
|---|-----------|-----|
| 1. Is your child generally happy and healthy and growing well? | Yes | No |
| 2. Does your child have any chronic or recurrent health problems? | No | Yes |
| 3. Is your child eating well? | Yes | No |
| 4. Does your child sleep well at night? | Yes | No |
| 5. Does s/he have any habits or behavior problems? | No | Yes |
| 6. On a scale of 1 (very low) to 5 (very good) how do you rate your child's self-esteem? | 1 2 3 4 5 | |
| 7. On a scale of 1 (very low) to 5 (very good) how do you rate your family's quality of communication? | 1 2 3 4 5 | |
| 8. Has your child had any serious illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 9. Has s/he had any of the childhood diseases? <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Roseola
<input type="checkbox"/> Hand-Foot-Mouth <input type="checkbox"/> Other | No | Yes |
| 10. Does your child have any allergies? _____ | No | Yes |
| 11. Does your child take any medications or supplements regularly?
(Circle) Vitamins Fluoride Other: _____ | No | Yes |
| 12. Are your child's immunizations up-to-date? | Yes | No |
| 13. Does your child brush and floss his or her teeth regularly? | Yes | No |
| 14. Does your child have regular dental checkups? | Yes | No |
| 15. Has your child ever been physically, mentally or sexually abused? | No | Yes |
| 16. Have there been any major changes, stresses or new health problems in the family recently? | No | Yes |
| 17. Is your child doing well in school?
Grade _____ School _____ | Yes | No |
| 18. Does your child have any special or unusual talents or abilities?
_____ | No | Yes |
| 19. Does everyone always use seat belts in the car? | Yes | No |
| 20. Do you have a working smoke alarm? | Yes | No |
| 21. Have you had formal CPR and First Aid training? | Yes | No |
| 22. Are there firearms in your home? | No | Yes |
| 23. Is the child exposed to cigarette or tobacco smoke at home? | No | Yes |
| 24. Does your child: <input type="checkbox"/> Play well in small groups of children
<input type="checkbox"/> Know right from left <input type="checkbox"/> Understand cause and effect | Yes | No |
| 25. Are there any special questions you would like to ask today?
1)
2)
3) | No | Yes |