Well Child Questionnaire

Pt. Name: _____ Date of Birth: _____ Today's Date: _____

Interval History

Has anything happened medically with your child since their last visit in our office? **Yes** **No**

Developmental

Motor Skills: (how the child moves/walks physically) Do you have concerns about your child's motor skills in comparison with other children their age? **Yes** **No**

Social/Language: (listening and speaking interaction) Do you have concerns about your child's social skills in comparison with other children their age? **Yes** **No**

Sexual Development: (skip if pt is male or under age 12)

Age at first period _____ Date of last period _____ No period yet _____

Sleep: How many hrs/night _____ How many hrs/day of naps _____

TV/Video games/Computer (non-homework use): How many hrs/day _____

Potty Trained: Yes No Not ready yet

Bedwetting: never rarely on occasion frequently

Attachment: (circle all that apply)

carries and object/blanket uses bottle uses pacifier sucks thumb/fingers

Nutrition

Dairy: (circle what applies)

Breastfeeding every _____hrs Whole milk ___oz/day 2% milk ___oz/day 1% milk ___oz/day Skim milk ___oz/day

Food: # of meals eaten per day _____ # of snacks eaten per day _____

Vitamins/suppliments: Does child take them? **No** **Yes:** how often _____ what kind _____

Teeth: Does your child brush their teeth daily? **Yes** **No** Date of last dental appt: _____

Concerns from parent/caregiver

Do you have any concerns regarding any of the above listed areas of the child's life?

_____

_____

_____

Social

Parents marital status: married separated divorced widowed unmarried

Child lives with: Mom & Dad Mom only Dad only foster parent adopted parent

Daycare: **Yes** **No**

Education: What grade: _____ Is the child doing well in school? **Yes** **No**

After school activities:

What hobbies does the child like to do? _____

Do they participate in a sport? **No** **Yes** which sport? _____

Is the child employed? **No** **Yes** How many hrs/week _____ What is the job? _____

Is the child exposed to tobacco smoke in the home **Yes** **No**

For patients age 12 and older:

Substance abuse:

Smoke tobacco? **No** **Yes** How much per day_____ How long have they smoked_____

Used to smoke? **No** **Yes** For how long _____

Used Illicit drugs? **Never** **Yes** If yes, did they go to rehab?_____ When? _____

Used alcohol? **Never** **Yes** If yes, did they go to rehab?_____ When? _____

Special fad diets? **Never** **Yes**

Sexual behavior:

Is the child sexually active? **No** **Yes** How many partners? _____

Abnormal behavior:

Circle any of the following that you have seen or have a concern about.

aggressive behavior depression extreme shyness thoughts of suicide(past or present)

Safety

Does the child always wear a seatbelt or the age-appropriate car seat?	**Yes**	**No**
Is the child supervised at all times while bathing?	**Yes**	**No**
Is the child supervised at all times while in a vehicle?	**Yes**	**No**
Is the child supervised at all times during outdoor play?	**Yes**	**No**
Does the child always wear a helmet while riding a bike or skating?	**Yes**	**No**
If there are guns in the home, are they locked up in a safe?	**Yes**	**No**
Are all medications locked up and out of reach from children?	**Yes**	**No**
Are all the cleaning supplies and poisons locked up and out of reach of children?	**Yes**	**No**

Environment

Does your home have exposed pipes or extremely old paint?	**Yes**	**No**
Has your child been around anyone that has been diagnosed with Tuberculosis?	**Yes**	**No**
Has your child been to a country that has Tuberculosis?	**Yes**	**No**

Is my child at risk for obesity quiz

Adapted from aafp.org journal in July 2008

#1 **Sweetened beverages:** Fruit juices (whole or concentrate), fruit drinks and punches, soft drinks, sports drinks, energy drinks, iced tea, flavored milk. A serving is 12 oz.

How many servings does your child consume in one day? (round up half servings)

☐ 0-1 servings = 0 ☐ 2 servings = 5 ☐ 3 servings = 10 ☐ 4 servings = 15 ☐ 5 or more servings = 20

#2 **Fast Food:** Includes burgers (with any kind of meat), hot dogs, french fries, chicken nuggets and onion rings

How many times a week does your child eat traditional fast food?

☐ 0 -1 times = 0 ☐ 2 times = 5 ☐ 3 times = 10 ☐ 4 times = 15 ☐ 5 or more times = 20

#3 **Family Meals:** Eating dinner while being supervised by at least one parent is protective against obesity.

How many times a week does your child eat dinner with at least one adult?

☐ 0-1 time = 20 ☐ 2-3 times = 10 ☐ 4-5 times = 5 ☐ 6-7 times = 0

#4 **Media time:** The amount of time your child spends watching TV, using a computer for non-homework time, playing video games or listening to music while sitting or lying still.

How much media time does your child have a day?

☐ 0-1 hour = 0 ☐ 1-2 hour = 5 ☐ 2-3 hours = 10 ☐ 3-4 hours = 15 ☐ more than 4 hours = 20

#5 **Physical Activity:** This includes most sports as long as your child gets out of breath at least once while playing. Walking, riding a bike, skateboarding etc all count even if you child is not out of breath. (PE class bowling, softball do not usually count)

How many days/week does your child participate in at least 30 min of the "out of breath" type activity?

☐ 0-1 day = 20 ☐ 2-3 days = 10 ☐ 4-5 days = 5 ☐ 6-7 days = 0

Scoring:

Total up the points from the above answers: _____ Then subtract that number from 100 and you get: _____

80-100 pts: Excellent score--Your child is on track that will help them achieve or maintain a healthy weight.

60-80 pts: Good score--Your child has many good habits but there is still room for significant improvement.

40-60 pts: Fair score--Your child needs to adopt many new behaviors in order to achieve/maintain a healthy weight

<40 pts: Poor score--Your child is at high risk of becoming or remaining obese. You should help your child adopt healthy behaviors in order help prevent long term obesity.