Child's name_____ Date_____

Annual Well Child Visits Ages Three to Twelve

Please help us learn more about your child's health and well being by completing this form. We do ask some personal questions about your child's home. If you do not wish to answer a question, please leave it blank. Thanks.

What concerns do you want to go over today?

_____

_____

Does you child have any new physical or emotional health issues? If yes, please explain

_____

_____

In the past year has your child been to the Emergency Room? ____
A specialist?_____ Another health care provider?_____If yes, please explain

_____

_____

Development:

Please list your concerns about your child's learning, development and behavior?

_____

Do you have any concerns about how your child talks and makes speech sounds? no_____ yes_____ a little_____

Do you have any concerns about how your child understands what you say? no_____ yes_____ a little_____

Do you have any concerns about how your child uses his hands or fingers to do things? no_____ yes_____ a little_____

Do you have any concerns about how your child uses his arms or legs? no_____ yes_____ a little_____

Do you have any concerns about how your child behaves? no_____ yes_____ a little_____

Do you have any concerns about how your child is learning to do things for himself/herself? no_____ yes_____ a little_____

Do you have any concern about how your child is learning preschool or school skills? no_____ yes_____ a little_____

Do you have any other concern? no___ yes___ a little___

Safety:

Do you have smoke detectors at home?_____

Do you put sunscreen on your child before going out in the sun?_____

If you have firearms are they locked up so a child or babysitter cannot get to them?

Does your child ever ride without a car seat or booster seat?_____

Does your child ride a bike, horse, snowmobile or ATV?_____
Do they wear a helmet?_____

Is your child around cigarette smoke? ___

Has your child had a close call with drowning, choking, getting burned or other hazard?_____

Healthy life style:

How much time does your child spend watching TV?_____
What programs does he or she watch?_____
Do they have a TV in their room?_____
How much other time does your child spend in front of a screen, for example playing video games, computer use other than for school work etc? _____

How much time does your child spend outside or getting other exercise? _____

Does your child enjoy reading?_____
How often do you read together?_____
Do you go to the library?_____

What did your child eat and drink yesterday?

Breakfast:_____
Lunch:_____
Supper:_____
Snacks:_____
Beverages:_____

How often do you brush your child's teeth?
Does your child take Fluoride?_____
Has your child been having trouble at day care or school?

Emotional Health:

How do you discipline your child? (saying no, yelling, redirecting, talking it through, consequences, distraction, time out, slap on the hand, spanking, other)
_____) *please circle*
Does this method work for you and your child?

Do you have a lot of stress in your life? (money troubles, medical problems of your own, serious illness or death in the family, needing to move, trouble at work, family conflicts or other troubles?)_____

Have you had trouble paying for your family's health insurance, medical expenses, housing, or your children's basic needs?_____

Is the use of alcohol or drugs an issue in your household?_____
Are you concerned about your own use of alcohol or drugs?_____
Is your child around anyone who is using drugs or drinking alcohol?_____

Have you been down or blue?_____
Do you feel anxious a lot?_____
Have you been unable to sleep or are you sleeping too much?_____
Are you having trouble concentrating or getting motivated ?_____

Do you feel well supported by friends and family?_____
How many people can you count on when you really need help?_____

Do you feel safe in your home?_____
Has anyone ever hurt or threatened you or your children?_____
Does your partner prevent you from seeing your friends or family?_____
Does your partner control your life in other ways?_____

Please mark any topics you would like to discuss at your child's appointment:

Techniques for guiding and disciplining your child
How to help your child grow and learn
What your child can understand at this age
What behaviors to expect at this age
How to soothe your child
How to support your child's immune system
How to help your child get along with others
Sibling relations
How to talk about emotions
How to take care of yourself
Dealing with anger
Stopping violence or emotional abuse at home
Treatment for alcohol or drug abuse
Treatment for depression
Financial assistance
Access to health insurance
Finding child care
Your child's nutrition
Obesity or being over weight
Sleep or napping troubles
Dental care
Fluoride
Vaccinations
Toilet training
Bed-wetting or soiling underwear
Masturbation
Child proofing your home
How to teach about dangerous places, objects or situations
How to protect your child from sexual abuse
Lead poisoning
Television, game boy or Internet use
Care for colds, vomiting, diarrhea, fever or other common illness
Any other_____

Vital signs:
Please do vital signs for children over 3 years:

Height:_____ Weight:_____

Blood pressure:_____/_____ Pulse:_____