5 Year Visit

NAME DATE

Do you have concerns about your child's…..

1. Physical well being or special health care needs?	YES	NO
2. Start of school or ability to perform?	YES	NO
3. Development? (i.e. walking, talking, drawing, writing name or ABC's)	YES	NO
4. Mood or behavior? (eg. Attention, hitting, temper,worries, participation,	YES	NO
mood or activity level?	YES	NO
5. Nutrition?	YES	NO
6. Sleep?	YES	NO
7. Bowel Habits?	YES	NO
8. Bed wetting?	YES	NO
9. Peer interactions?	YES	NO

Does your child….

1. Balance on 1 foot, hop and skip?	YES	NO
2. Tie a knot?	YES	NO
3. Draw a person with 6 body parts?	YES	NO
4. Copy squares and triangles?	YES	NO
5. Print some letters and numbers?	YES	NO
6. Have good articulation?	YES	NO
7. Count to 10 and name 4 colors?	YES	NO
8. Listen and attend?	YES	NO
9. Dress and undress with minimal assistance?	YES	NO

Tuberculosis Screen (TB)

1. Has a family member or contact had tuberculosis disease?	YES	NO
2. Has a family member had a positive TB test?	YES	NO
3. Was your child born outside the US, Canada, Australia, New Zealand or Western Europe?	YES	NO
4. Has your child traveled to a high risk country for more than 1 week?	YES	NO

LEAD Screen (Pb)

1. Does your child live in or regularly visit a house built before 1950?	YES	NO
2. Does your child live in or visit a house built before 1978 with recent		
remodeling or renovation? (with in 6 months)	YES	NO
3. Have a sibling or playmate who now or did have lead poisoning?	YES	NO

over

Do you have any other concerns you wish to discuss? YES NO

Office use only

WT HT BP BMI%tile