

6 & 7 Year Visits

NAME

DATE

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

- | | | |
|---|-----|----|
| 1. Nutrition or eating habits? | YES | NO |
| 2. Bowel or urinary habits, including bed wetting? | YES | NO |
| 3. Mood changes, sadness or anxiety? | YES | NO |
| 4. Sleep habits? | YES | NO |
| 5. Allergies? | YES | NO |
| 6. Progress in school? | YES | NO |
| 7. Happiness in school? | YES | NO |
| 8. Ability to sit and listen? | YES | NO |
| 9. Ability to learn? | YES | NO |
| 10. Willingness to follow rules? | YES | NO |
| 11. Aggressiveness? | YES | NO |
| 12. Ability to get along with classmates or teachers? | YES | NO |
| 13. Lack of energy? | YES | NO |
| 14. Behavior in the home? | YES | NO |

Does your child...

- | | | |
|---|-----|----|
| 1. Use a child safety restraint in the car? | YES | NO |
| 2. Wear a bicycle helmet? | YES | NO |
| 3. Play outside most days? | YES | NO |
| 4. Have limits on TV and screen time? | YES | NO |
| 5. Have good hygiene? | YES | NO |
| 6. Participate in sports or clubs? | YES | NO |
| 7. Visit a dentist? | 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 |

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

Office use only

WT HT BP BMI%tile