8-10 Year Visit

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 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
8. Have adult care and supervision after school?	YES	NO
9. Get 6o minutes of exercise everyday?	YES	NO
10. Get counseling from parents on drugs, alcohol and tobacco?	YES	NO

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

over

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

Office use only

WT HT BP BMI%tile