

Health Information Update (7 Years Old)

INTAKE

How many ounces of milk does your child drink/day? _____ Ounces What kind? _____
How many meals per day does your child eat? _____ How many snacks per day? _____
How many servings/**DAY** does your child have of: _____ Fruits _____ Veggies _____ Whole Grains
How many servings/**DAY** does your child have of: _____ Cheese/yogurt
How many servings/**WEEK** does your child have of: _____ Meat _____ Beans _____ Nuts _____ Eggs _____ Fish
How many ounces/**DAY** does your child have of: _____ Juice _____ Pop
How often does your child eat sweets? 15 or more x/wk 8-14x/wk <8x/wk

OUTPUT

How many stools does your child have per week? _____ What is the consistency? _____
Do you see any blood in the stool? Yes No

SLEEP

Where does your child sleep? Parent's room Own room Room with sibling
Do you have a bedtime routine? Yes No Is reading part of the bedtime routine? Yes No
Is there a TV or computer in your child's room? Yes No
Does your child watch the screen or play on a computer before or at bedtime? Yes No
Bedtime _____ pm Wake time _____ am
Does your child wet the bed at night? Yes No
Any sleep problems? Yes No Explain: _____

SAFETY

What does your child ride in? Booster Car seat None
Wear a helmet? Yes No

CHILDCARE/SCHOOL

Who is your child home with after school? Parent Babysitter Family member After school care
Name of school: _____ What grade? _____
How are grades? _____ Concerns: _____

BEHAVIOR/DEVELOPMENT

Describe your child's temperament (happy, calm, etc.) _____
How do you discipline your child when needed? _____

OTHER

How many hours of screen time does your child watch/day? School day _____ hrs Non-school day _____ hrs
How many minutes/ day does your child get physical activity? 0-15min 15-30 min 30-60 min
What activities/hobbies does your child participate in? _____
How many times per day to your brush your child's teeth? _____ Flosses? _____ per week
When was your child's last visit to the dentist? _____ Any cavities? Yes No
What is your water source? City Community well Personal well Bottled water
Do you drink the tap water? Yes No
List any medications or vitamins/supplements your child takes: _____
Do you need any medication refills? _____
Concerns? _____

Pediatric Symptom Checklist – Parent

Please mark under the heading that best fits your child:

Never Sometimes Often

- | | | | |
|--|-------|-------|-------|
| 1. Fidgety, unable to sit still..... | _____ | _____ | _____ |
| 2. Feels sad, unhappy..... | _____ | _____ | _____ |
| 3. Daydreams too much..... | _____ | _____ | _____ |
| 4. Refuses to share..... | _____ | _____ | _____ |
| 5. Does not understand others people's feelings..... | _____ | _____ | _____ |
| 6. Feels hopeless..... | _____ | _____ | _____ |
| 7. Has trouble concentrating..... | _____ | _____ | _____ |
| 8. Fights with other children..... | _____ | _____ | _____ |
| 9. Is down on him or herself..... | _____ | _____ | _____ |
| 10. Blames others for his or her troubles..... | _____ | _____ | _____ |
| 11. Seems to have less fun..... | _____ | _____ | _____ |
| 12. Does not listen to rules..... | _____ | _____ | _____ |
| 13. Acts as if driven by a motor..... | _____ | _____ | _____ |
| 14. Teases others..... | _____ | _____ | _____ |
| 15. Worries a lot..... | _____ | _____ | _____ |
| 16. Takes things that do not belong to him or her..... | _____ | _____ | _____ |
| 17. Distracted easily..... | _____ | _____ | _____ |