

# Health Information Update (9 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

Does your child wear a seat belt in the car?  Yes  No Wear a helmet?  Yes  No  
Where does your child sit in the car?  Back seat  Front seat

## CHILDCARE/SCHOOL

Who is your child home with after school?  Mom  Dad  Babysitter  Family member  
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.....                             | _____ | _____ | _____ |