Health Information Update (10 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

Any sleep problems? ◯ Yes ◯ No Explain: ____

SAFETY

Does your child use a seat belt? ◯ Yes ◯ No Does your child sit in ◯ Front seat and/or ◯ Backseat

Wear a helmet? ◯ Yes ◯ No

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 does your child brush his/her 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……………………………………	____	________	_____