

6-7 Year Old Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your child's...

- 1. Bowel movements Yes No
- 2. Congestion or wheezing? Yes No
- 3. Skin color or rashes (circle one)? Yes No
- 4. Overall development? Yes No
- 5. Communication skills? Yes No
- 6. Bed wetting, soiling, or urinary control? Yes No
- 7. Weight loss or gain? Yes No
- 8. Recurrent ear infections? Yes No
- 9. Nose bleeds or bruising? Yes No
- 10. Weakness with walking up stairs, running, or climbing? Yes No
- 11. Behavior at school, home, or daycare? Yes No
- 12. Food allergies? Yes No
- 13. Seasonal allergies? Yes No
- 14. Chest pain? Yes No
- 15. Chronic abdominal pain? Yes No
- 16. Joint pain, joint swelling or limp? Yes No
- 17. Overall progress/happiness/performance at school? Yes No
- 18. Poor diet and/or picky eating? Yes No

Answer the following:

- 19. Is your child exposed to tobacco smoke? Yes No
- 20. Were there any problems with immunizations in the past? Yes No
- 21. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? Yes No
- 22. Does your child eat non-food substances such as paint chips? Yes No
- 23. Is your water source from a well? Yes No
- 24. Does your child have any speech delays? Yes No
- 25. Have problems sitting in their seat and paying attention at school? Yes No
- 26. Is your child on the computer or playing video games or watching TV more than 2 hours per day? Yes No

Does your child...

- 27. Interact positively with teachers and friends and babysitters and siblings? Yes No
- 28. Know all of his/her colors? Yes No
- 29. Ride a bike with or without training wheels? Yes No
- 30. Run well and keep up with their friends? Yes No

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Answer the following:

- 31. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
- 32. Do you know CPR? Yes No
- 33. Are you giving your child a multivitamin with iron?..... Yes No
- 34. Is your child eating all food groups: fruits, meats, and vegetables?..... Yes No
- 35. Is your child brushing their teeth?..... Yes No
- 36. Is your child seeing the dentist every 6 months?..... Yes No
- 37. Does your child ride in a booster seat or car seat in the back seat?..... Yes No
- 38. Participate in a sport or other organized activity? Yes No
- 39. How many ounces of milk does your child drink in one day? _____ What kind? _____
- 40. How many ounces of juice does your child drink in one day? _____

Screening questions for Tuberculosis:

- 1. Do you have a family member with TB or any contact with someone who has TB? Yes No
- 2. Do any family members have a positive TB test? Yes No
- 3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? Yes No
- 4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? Yes No
- 5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? Yes No
- 6. Do you plan to travel to a high risk country (one NOT listed above) within the next year? Yes No

Lead Screening:

Does your child...

- 1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) Yes No
- 2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? Yes No
- 3. Have a sibling or playmate who now has or did have lead poisoning? Yes No
- 4. Is your child a refugee from another country? Yes No

Name and Ages of Brothers _____
Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss?..... Yes No

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____
 Date of Birth: _____ Today's Date: _____

| Please mark under the heading that best fits your child: | | | NEVER | SOMETIMES | OFTEN |
|--|---|---|-------|-----------|-------|
| ◆ | Fidgety, unable to sit still | ◆ | 0 | 1 | 2 |
| * | Feel sad, unhappy | * | 0 | 1 | 2 |
| ◆ | Daydream too much | ◆ | 0 | 1 | 2 |
| □ | Refuse to share | □ | 0 | 1 | 2 |
| □ | Do not understand other people's feelings | □ | 0 | 1 | 2 |
| * | Feel hopeless | * | 0 | 1 | 2 |
| ◆ | Have trouble concentrating | ◆ | 0 | 1 | 2 |
| □ | Fight with other children | □ | 0 | 1 | 2 |
| * | Down on yourself | * | 0 | 1 | 2 |
| □ | Blame others for your troubles | □ | 0 | 1 | 2 |
| * | Seem to be having less fun | * | 0 | 1 | 2 |
| □ | Do not listen to rules | □ | 0 | 1 | 2 |
| ◆ | Act as if driven by a motor | ◆ | 0 | 1 | 2 |
| □ | Tease others | □ | 0 | 1 | 2 |
| * | Worry a lot | * | 0 | 1 | 2 |
| □ | Take things that do not belong to you | □ | 0 | 1 | 2 |
| ◆ | Distract easily | ◆ | 0 | 1 | 2 |

| | | | |
|-----------------|---------------|---------------|-------------------------|
| OFFICE USE ONLY | | | |
| Total ◆ _____ | Total □ _____ | Total * _____ | Grand Total ◆+□+* _____ |