Woodinville Pediatrics 5-6 year Questionnaire

Patient Name:_____ Date:_____

Parental concerns this visit: _____
_____

Current Medications: _____
Current Allergies: _____

Family
After school care ___yes ___no school:_____
Changes since last visit _____

Diet
5 servings of fruit/vegetable ___yes ___no
Limited sweetened liquids ___yes ___no
Vitamins/Supplements _____
Diet Concerns ___yes ___no
Diet comments _____

Sleep
Sleep concerns ___yes ____no

Tobacco Exposure ____yes ____no

Behavior Concerns ____yes ____no

Physical Activity Play time (60m/d) ___yes ___no
Screen time (<2hr/d) ___yes ___no

School
Grade _____ Special education ___yes ___no
Social concerns ____yes ___no Social interaction _____
Performance concerns ____yes ___no
Behavior concerns ____yes ___no
Attention concerns ____yes ___no
Homework concerns ____yes ___no
Parent/Teacher Concerns ____yes ___no
comments: _____
Parent child interact concerns ____yes ___no
comments: _____
Cooperation concerns ____yes ___no

Development
Language: ___ Good articulation/language skills
Learning: ___ Draws person (6+ body parts)
___ Prints some letters and numbers
___ Copies squares, triangles
___ Counts to 10
___ Names 4 or more colors
___ Follows simple directions

___ Listens and attends

Motor: ___ Balances on 1 foot

___ Hops and skips

___ Able to tie knot

Additional comments: _____

_____