Woodinville Pediatrics 9-10 years Questionnaire

Patient Name:______________________________ Date:_______________________

Parental concerns this visit: ____
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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
Comments: ____

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: ____
Sib interact concerns ___yes ___no

Development
___ Eats healthy meals and snacks
___ Participates in an after school activity
___ Has friends
___ Is vigorously active for 1 hour a day
___ Has a caring family
___ Is doing well in school

___ Is getting chances to make own decisions
___ Feels good about self
___ Does an activity really well

Additional comments: ____

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