

Parent Questionnaire for Patients (Ages 2-5 years)

Name:	Acct. No:
Age:	DOB:
Phone:	PC:
Date:	Clinician:

Parent questionnaire – Please take the time to answer the following questions in order for us to better care for your child.

		Please Circle Answer		Counseled/Referred
Health	Does your child have any food, medication, or environmental allergies?	No	Yes	
	Has your child required surgery, hospitalization, ER or urgent care visits since his/her last checkup? Please circle	No	Yes	
	Do you have any concerns about your child’s height, weight or development (including language, vision or hearing)? Please circle	No	Yes	
	Do you have well water and/or a reverse osmosis filter?	No	Yes	
	Have there been any changes in a family member’s health since your last visit (i.e. new onset diabetes, high cholesterol, unhealthy weight, etc)?	No	Yes	
Nutrition	Do you and your family eat dinner together most nights?	Yes	No	
	How many servings a day does your child get of the following? Please circle Fruits 0-1 2-3 3 or more Vegetables 0-1 2-3 3 or more Sweetened drinks (juice, soda, sports drink) 0 1 2 or more			
	How many meals does your child eat out per week? Please circle 0 1-2 2 or more			
Social	Does your child attend preschool or daycare?	No	Yes	
	Is your child involved in organized activities? (swimming, dance, ECFE, etc.) Please list	Yes	No	
	How many hours of TV, computer or video game time does your child get per day? Please circle 0-1 2-3 3 or more			
	Is there a TV, VCR, DVD, video game or computer in your child’s bedroom?	No	Yes	
	Has there been a major change in your life recently due to moving, divorce, remarriage, new job, illness or other stressor? Please circle	No	Yes	
	Do you feel you or your child need help with discipline and/or behavior issues?	No	Yes	
	Do you often feel stressed, anxious or angry?	No	Yes	
	Do you and your spouse/partner agree on rules?	Yes	No	
	Do you have any concerns regarding the use of alcohol or drugs by anyone in your family or by anyone caring for your child?	No	Yes	
Safety	Do you have any concerns regarding conflict or violence that your child might by exposed to?	No	Yes	
	Do you keep handguns, rifles, BB guns, bow and arrows or other weapons in your home? Please circle	No	Yes	
	Does your child always use a bike helmet when biking with you or on his/her own bicycle or tricycle?	Yes	No	
	Does your child always sit in a car seat or booster seat? Please circle	Yes	No	
	Do you have working smoke and carbon monoxide detectors?	Yes	No	