PARK VIEW PEDIATRICS

Questionnaire for PARENTS of a School Age Child (age 6-10)

Welcome to your Park View Pediatrics team. Thank you for entrusting your child's health care with us. Please take a few moments to answer the following questions.

Are there any specific concerns or problems you would like to discuss at this visit?

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Have there been any changes or challenges at home we should know about?

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Does your child see any other providers such as an herbalist, chiropractor, or other healer?	Yes	No
Does your child see the dentist regularly?	Yes	No
Does your child use dental floss daily?	Yes	No
Does your child eat at least 5 servings of fruits and vegetables each day?	Yes	No
Does your child eat at least 3 servings of calcium rich foods each day?	Yes	No
Does your child eat more than 1 fast food meal per week?	Yes	No
Does your child get at least 60 minutes of physical activity each day?	Yes	No
How many hours of sleep does your child get each night?		
Is there a television in your child's bedroom?	Yes	No
Does your child spend more than 2 hours in front of a screen each day?	Yes	No
Does your child have any problems in school?	Yes	No
Does your child have a friend or group of friends they feel comfortable with?	Yes	No
Does your child wear a helmet for biking, skateboarding, skiing, snowboarding?	Yes	No
Does your child ride in a booster seat?	Yes	No
How tall should your child be to ride in a seatbelt?	50"	57"
Does your child use a seatbelt?	Yes	No
Does your child use sunscreen?	Yes	No
Are there any guns in the home?	Yes	No
Have you talked about what to do if they encounter a gun at someone's home?	Yes	No
Has your child travelled outside the USA in the past 5 years?	Yes	No
Does your child live with anyone who uses tobacco?	Yes	No
Do you spend time talking with your child each day?	Yes	No
Even with ups and downs, do you feel your child enjoys life?	Yes	No
Do you talk about relationships with your child?	Yes	No
Do you feel you and your child get along reasonably well?	Yes	No