Child/Parent Questionnaire

(4-11 y/o)

Child's Name: _____ DOB:_____

Please answer the following questions so we can help you ***set goals for your child's health***

Do you have any questions about injury prevention*? If yes, please circle*

Safe street habits	*water safety*	*use of safety equipment (helmet, pads)*
smoke detectors	*sports safety*	*sexual abuse prevention*
booster seat/seatbelt	*sunscreen*	*monitor TV/Video games/internet use*
smoke free home	*bullying*	*supervision of child and friends*

How many hours/day does your child spend in front of TV/computer/video games?

- *Limit screen time to 2 hours/day*

Do you have any concerns regarding your child's eating habits? If yes, please circle

5 servings of fruits/vegetables	*dairy calcium/Vitamin D*	*protein*
limiting juice to 6-8 oz /day	*soda/sweet drinks*	*fast foods*
unhealthy snacks or portion size	*other: _____*	

- *Family should eat meals together at least 3-4X/week with TV off*
- *For healthy eating, go to www.choosemyplate.gov*

Does your child engage in exercise at least 30 minutes/day, 5 days/week? Yes No

Do you have any concerns about your child's development? If yes, please circle

School/learning	*behaviors*	*moods/emotions*	*sleep*
growth	*dental*	*bowel habits*	

Are there any problems at home or school that might affect your child? Yes No

Are there things that make it hard for you to take care of your child's health that you would like to discuss? *Yes No*

Any other concerns: _____

_____