

Parent Questionnaire

(6m-3 yr)

Child's Name: _____ Today's Date: _____

Please answer the 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

Falls/burns	water safety	crib safety
choking	car seat	childproofing your home
smoke free home	sunscreen	never leave child alone
other: _____		

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

- Avoid TV watching if less than 2 years old, choose alternative activities.
- Limit screen time to no more than 1-2 hrs/day if over 2 years old.
- No TV in bedroom.
- Encourage physical activities as a family.

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

3 meals/2-3 snacks a day	dairy/calcium/vitamin D	protein
limiting juice to 2-3oz / day	soda/sweet drinks	fast foods
unhealthy snacks	fluoride	
other: _____		

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

Do you have any additional concerns for your child related to the following? If yes, please circle.

Growth	sleep/naps	teeth/dental habits	bowel patterns
other: _____			

Are there any problems at home or daycare 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? _____
