5 Year Well Child Check

Name_____ School _____ Grade _____

Allergies_____Current Meds_____

Is your child healthy?	**Yes**	**No**_____
Has your child had any recent illness?	No	Yes_____
Has your child had any injuries?	No	Yes_____
Is your child a picky eater?	No	Yes_____
Does your child take a vitamin or supplement?	Yes	No
Is there Fluoride in your drinking water? (city water=yes)	**Yes**	**No**
Do you have concerns about your child's speech?	No	Yes_____
Does your child adjust easily to new situations/children?	Yes	No_____
Does your family eat a well-balanced diet?	Yes	No
Has there been any recent change to your family structure?	**No**	**Yes**_____
Do you feel you have a good relationship with your child?	Yes	No_____
Does anyone in your household smoke?	No	Yes
Is your child in kindergarten or preschool?	Yes	No_____
Are you familiar with the 5-3-2-1-0 Healthy Lifestyles?	*Yes*	*No*
Do you have concerns about behavior or discipline?	*No*	*Yes*_____
Does your child see a dentist?	*Yes*	*No*
Are there any unsecured firearms in the house?	*No*	*Yes*_____
Does your child have more than 2 hrs of screen time/day?	*No*	*Yes*
Is your child in a car seat or booster seat?	*Yes*	*No*
Is your child dry at night?	*Yes*	*No*

Do you have any other concerns?_____

_____

Development (Do not complete if given the Ages and Stages Questionnaire)

Does your child dress self without help?	Yes	No
Does your child know his/her address/telephone number?	Yes	No
Does your child understand opposites?	Yes	No
Can your child count on his/her fingers?	Yes	No
Can your child copy a square or triangle?	Yes	No
Does your child draw a person with arms/legs?	Yes	No
Does your child recognize most of the alphabet?	Yes	No
Does your child know his/her colors?	Yes	No
Does your child write some letters?	Yes	No
Does your child play make-believe/dress up?	Yes	No
Is your child able to skip?	Yes	No
Can your child walk heel to toe?	Yes	No
