Name of Child: ______________________________ School _________________ Grade ____

6 Year Well Child

Allergies_____________________ Current Medications_______________________
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Is your child's general health OK? Yes No ______________________________
Has your child had any recent illnesses? No Yes ______________________________
Has your child had any recent injuries? No Yes ______________________________
Do you have any concerns about child's eating habits? No Yes______________________________
Does your child take any vitamins or supplements? Yes No ______________________________
Does your child get fluoride by supplement or in your water? Yes No
Are your child's stool and urine habits OK? Yes No ______________________________
Does your child get at least 1 hour of daily exercise? Yes No
Do you feel your child has good friendships? Yes No ______________________________
Has your family situation remained stable? Yes No ______________________________
Is your child in a totally smoke-free environment? Yes No ______________________________
Are you comfortable with your childcare plans? Yes No ______________________________

Development:

Do you have any concerns about your child's development, behavior or discipline? No Yes ______________________________
Is your child proud of their personal achievements? Yes No ______________________________
Is your child making good progress in school? Yes No ______________________________
Has your child's attendance been good? Yes No ______________________________
Have you reviewed your child's report card? Yes No ______________________________
Is your child able to follow school rules? Yes No ______________________________
Does your child play well with their peers? Yes No ______________________________
Do you acknowledge and praise your child's schoolwork? Yes No ______________________________
Does your child talk with you about his/her school experience? Yes No ______________________________
Has your child's teacher been satisfied with your child's progress in school? Yes No ______________________________

Do you have any concerns with your child's sleeping? No Yes ______________________________
Has your child seen a dentist? Yes No ______________________________
Do you have any concerns with nighttime dryness No Yes ______________________________
or constipation? No Yes ______________________________
Are you aware of and try to implement 5-3-2-1-0 in your family? Yes No ______________________________
Does your child watch more than 2 hrs/day of screen time? No Yes ______________________________

Do you have any other concerns?____
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01/2013