9-10 Year Well Child   Male

Name of Child:______________________________ School ____________________Grade ____

Allergies_________________ Current Medications______________________

Is your child's general health OK? Yes No ______________________________________
Has your child had any recent illnesses? No Yes ______________________________________
Has your child had any recent accidents? No Yes ______________________________________
Does your child exercise regularly? Yes No ______________________________________
Do you have any concerns about your child's eating habits? No Yes______________________________________
Do you have any concerns about your child's favorite foods? No Yes______________________________________
Do you have any concerns with your child's sleeping? No Yes ______________________________________

Do you feel your child has good friendships? Yes No ______________________________________
Has your family situation remained stable? Yes No ______________________________________
Do you have frequent family meals together at home? Yes No ______________________________________
Is your child in a totally smoke-free environment? Yes No ______________________________________
Are you comfortable with your childcare plans? Yes No ______________________________________
Are you and your child comfortable asking each other
questions about important topics? Yes No ______________________________________

Development:

**Have you reviewed your child's report card or
IEP if they have one? Yes No** ______________________________________
Does your child have good school attendance? Yes No ______________________________________
Is your child at grade level in reading? Yes No ______________________________________
Is your child at grade level in math? Yes No ______________________________________
Is your child getting any extra help in school? No Yes ______________________________________
Is your child able to follow school rules? Yes No ______________________________________
Is your child proud of their school achievements? Yes No ______________________________________
Have you visited your child's classroom? Yes No ______________________________________
Have you participated in your child's school activities? Yes No ______________________________________
Does your child talk with you about their school experiences? Yes No ______________________________________
Has your child expressed any special interests or
talents they might want to pursue? Yes No ______________________________________
Do teachers have positive or negative feedback about
your child's school performance? Positive Negative ___________________________________
Does your child have a best friend? Yes No ______________________________________
Is your child involved in hobbies or sports? Yes No ______________________________________
Do you or your child have any other concerns? No Yes ______________________________________

Does your child help with household chores? Yes No ______________________________________
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 ______________________________________

On a 1 to 5 scale, how does your child feel his life is going?

Terrible		*OK*		*Great*
1	*2*	*3*	*4*	*5*