Ages 6-9 Year Health Survey (2 SIDES)

Child's
Name_____

Allergies?_____

Meds?_____

Vitamins?_____

Family:
Have there been any significant change in your family life this year? (i.e. move, divorce, illness, etc)

- ☐ No
- ☐ Yes_____

Education:
Child's school/grade_____
Any concerns?

- ☐ No
- ☐ Yes_____

Electronics & Media:
How many hours of non-school related computer/TV/video on a TYPICAL day?_____

Activities:
What physical activities does your child participate in and how often? (i.e. soccer/dance)

What other organized activities does your child participate in and how often? (i.e. art/music)

Safety:

- ☐ Booster seat (*until 8 yr AND 60 lb or 4'9"*)
- ☐ Rear seatbelt
- ☐ Front seatbelt *(not recommended until 12 yr AND 120 lbs)*

In your home do you have:
Anyone who smokes? (inside or out, any caregiver)

- ☐ Yes
- ☐ No

Smoke detectors?

- ☐ Yes
- ☐ No

Carbon Monoxide detectors?
(remember to bring to vacation homes!)

- ☐ Yes
- ☐ No

Does your child wear a helmet for biking, skiing, skating, scootering?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Not applicable

Are there any **guns** in your home?

- ☐ No
- ☐ YES- safely stored via:

_____

Is there a **pool** at your home?

- ☐ No
- ☐ Yes; there is a: O Fence O Safety cover

Do you own any animals/pets?

- ☐ No
- ☐ Yes, _____

Sleep:
Any concerns?_____

How many hours on a TYPICAL night?_____

Bowel Movements:
Any concerns?_____

How many BMs on a typical day?_____

Are their BMs LOOSE/SOFT/HARD/PAINFUL? (circle)

***PLEASE COMPLETE THE SECOND SIDE →**

Nutrition:

Is your child on a modified diet (i.e. vegan, vegetarian, gluten or dairy free)?

- ☐ No
- ☐ Yes, _____

Do you have any **concerns** about your child's diet?

- ☐ No
- ☐ Yes, _____

On a **typical** day, how many servings does your child get of:

Fruit (serving = 1 tennis ball) _____

Vegetable (serving = ½ baseball cooked, 1 baseball fresh)

_____

Dairy (serv = 1 cup milk/yogurt, 1.5 oz cheese) ____

Fish/Egg/Red Meat or Poultry:
(2-3 oz meat/fish/chicken/tofu, ½ cup beans,
2 tbsp nut butter, 1-2 eggs)

_____

Dental:

Any dental concerns?

- ☐ NO
- ☐ YES_____

Does your child see the dentist twice yearly?

- ☐ NO (last seen_____)
- ☐ YES

Fluoride source:

- ☐ City water (home or daycare)
- ☐ Fluoride Vitamin
- ☐ Fluoride Rinse
- ☐ None