3 Year Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

6	Is a child eating 5 servings of fruits and vegetables daily?	YES	NO
7	When your child has grains (cereal, bread, pasta, crackers, waffles, rice, etc), are they mostly whole grains?	YES	NO
8	Does your child eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese)?	YES	NO
9	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than 2-3 days per week?	NO	YES
10	Does your child snack more than 2 times a day on foods other than fruits and vegetables?	NO	YES
11	Does your child drink juice or other sweetened drinks?	NO	YES
12	Do you give your child any vitamins or supplements?	NO	YES
13	Are you worried about your child's weight?	NO	YES

Oral Health

14	Does your child see a dentist at least 2 times a year? **(If your answer is yes, please skip ahead to #19)**	YES	NO	
	ANSWER #15-18 *ONLY* IF YOUR CHILD DOES *NOT* SEE A DENTIST			
15	Has any caregiver had cavities/dental decay in the past year?	NO	YES	
16	Does your child drink something other than water from a cup continually and/or snack frequently throughout the day?	NO	YES	

17 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO	NOT SURE
18 Do your brush your child's teeth with a fluoride-containing toothpaste (size of a pea) twice daily?	YES	NO	

Elimination

19 Does your child have regular soft bowel movements (poop)?	YES	NO
20 Is your child toilet (potty) trained?	YES	NO

School

21 Is your child in preschool or childcare?	YES	NO

Activity / Exercise / Screen Time

22 Does your child have more than 1 hour of screen time per day (TV, smartphones, tablets)?	NO	YES
23 Does your child have any screen time in his/her room?	NO	YES
24 Do you read to your child every day?	YES	NO
25 Do you and your family do active and educational activities like walking, bicycling, swimming, going to libraries or going on nature walks?	YES	NO
26 Do you eat meals together as a family?	YES	NO
27 Does your child play actively for at least 1 hour every day	YES	NO
28 Does your child sleep 10 to 13 hours/day (nighttime plus naps)?	YES	NO

Social Stressors

29 Have there been any major changes or stresses in your family recently?	NO	YES	
30 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
31 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
32 Is there someone in your life that hurts you or your children?	NO	YES	

Behavior

33 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
34 Do you praise your child when he/she is behaving well?	YES	NO

35 Do you give your child choices?	YES	NO

Development

36 Does your child put 2 or 3 sentences together?	YES	NO
37 Can people usually understand what your child is saying, even non-family members?	YES	NO
38 Can your child count to 5 or more?	YES	NO
39 Does your child know 2 or more colors?	YES	NO
40 Does your child pretend play, like using a telephone or playing house?	YES	NO
41 Can your child draw a person with at least two body parts?	YES	NO
42 Does your child walk up and down stairs alternating feet? (one foot on each step)	YES	NO
43 Does your child feed himself/herself well using a fork and spoon?	YES	NO
44 Can your child dress or undress with only a little help?	YES	NO
45 Can your child throw a ball overhand?	YES	NO
46 Can your child balance on one foot?	YES	NO
47 Is your child toilet (potty) trained during the day?	YES	NO
48 Can your child name a friend?	YES	NO

Safety

49 Do you watch your child when he/she plays outside?	YES	NO	
50 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO	
51 Does your child wear a helmet when riding a scooter, tricycle, or bicycle?	YES	NO	
52 Does anyone smoke or vape around your child?	NO	YES	
53 Is there a gun in the home?	NO	YES	
a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY
54 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO	
55 Do you put sunscreen on your child when outside for a long time?	YES	NO	
56 Do you have the number for Poison Control?	YES	NO	
57 Is there a swimming pool, pond or lake near your home?	NO	YES	

a. If yes, it is secured so that your child cannot access it?	YES	NO	DOESN'T APPLY

Tuberculosis

58 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
59 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
60 Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
61 Has your child traveled to a high-risk country for more than a month?	NO	YES