Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

## 6 – 10 Year Old Parent Observations

Are there any concerns you would like to discuss today?_____

_____

Activities/interests:

How active is your child? ☐ very active ☐ fairly active ☐ occasionally active ☐ little/none

List any extracurricular activities (i.e. a sport, dance): _____

List any interests (i.e. instrument, art, playing outside): _____

How much screen time (TV/tablet/phone/video games) does your child have per day? _____

Are there parental controls/monitoring in place for electronics/social media? Yes No

Diet/Physical Development/Sleep:

Does your child eat well (i.e. has consistent appetite, not too picky)? Yes No

What does your child drink? ☐ water ☐ milk ☐ juice ☐ soda/caffeinated drinks

If picky, what does your child dislike?_____

Any concerns about voiding or stooling? (i.e. constipation, bedwetting) Yes No

Do you have any concerns regarding your child's growth or puberty? Yes No

Does your child have any problems with sleep? Yes No

How many hours of sleep does your child get each night? _____

School:

What school does your child attend?_____ Grade _____

What are your child's grades usually? _____

Do you have any concerns regarding your child's school performance? Yes No

Does your child enjoy school and have good in-class behavior? Yes No

Does your child have any problems with bullying/cyberbullying? Yes No

Social/Behavior:

Are there any family or home issues we should discuss? Yes No

Any concerns about your child's behavior (i.e. anxiety, mood swings)? Yes No

Are there problems with discipline? Yes No

Does your child have close friends or make friends easily? Yes No

Do you approve of your child's friends? Yes No

Safety/Preventative Health:

Does your child always buckle his/her seatbelt? (or booster if shorter than 4'9") Yes No

Does your child brush his/her teeth twice daily with a fluoride toothpaste? Yes No

Has your child seen a dentist in the last 6 months? Yes No

Does your child always wear a helmet when riding bike/scooter/skiing/etc? Yes No

Have you discussed trampoline/water safety with your child? Yes No

Do you own a gun? Yes No If yes, is it stored safely (i.e. locked case)? Yes No

Are your child's immunizations up to date? Yes No

Does your child have any allergies (that you know of)? Yes No

Please list any medications or supplements your child took this week: _____

_____