KAISER PERMANENTE®

# Well-Visit Questionnaire
## Children Age 6 to 9 Years

**Your child is 6 to 9 years old!**

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

| **Do you have specific concerns? Check all that apply, then briefly describe your concern:** | |
|---|---|
| ☐ Well Visit ☐ Abdominal pain ☐ ADHD ☐ Allergies ☐ Behavior ☐ Cold/flu ☐ Constipation ☐ Cough ☐ Earache ☐ Fever ☐ Growth/nutrition ☐ Injury ☐ Learning ☐ Rash ☐ School issues ☐ Sore throat ☐ Speech ☐ Vaccines ☐ Vomiting ☐ Other (please explain):_____ Briefly describe your concern:_____ | |
| **Health Changes** | |
| Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____ | ☐ Yes ☐ No |
| Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____ | ☐ Yes ☐ No |
| Does your family have a history of blood relatives with heart problems (heart attack, stroke, or surgeries) before 55 for men, or 65 for women? Please include parents, aunts, uncles, or grandparents. | ☐ Yes ☐ No |
| **Dental Health** | |
| Does your child see a dentist twice a year? | ☐ Yes ☐ No |
| **School** | |
| What grade is your child in? _____ | |
| What is the name of your child's school? _____ | |
| Does your child receive educational services or accommodations (Check all that apply): ☐ No ☐ IEP ☐ 504 plan ☐ Special education ☐ Therapy (OT/PT/Speech) ☐ Other (please describe): _____ | |
| Do you have concerns about your child's learning, attention, or behavior in school? If Yes, please describe: _____ | ☐ Yes ☐ No |
| **Tuberculosis Screening** | |
| Was your child born in or traveled to a country with a high risk for tuberculosis? This would be a country that is **not** in the USA, Canada, Australia, Western Europe, or New Zealand. | ☐ Yes ☐ No |
| Has there been a family member or contact with TB or a positive tuberculin skin test? | ☐ Yes ☐ No |
| **Nutrition, Feeding and Supplements – Tell us about what your child eats.** | |
| My child eats at least 3 servings of fruits and/or vegetables daily, and variety over the course of a week: | ☐ Yes ☐ No |
| My child has a daily source of iron in their diet, like meat or beans: | ☐ Yes ☐ No |
| My child has 3 daily servings of calcium-rich foods: | ☐ Yes ☐ No |
| We eat together as a family: | ☐ Yes ☐ No |
| Please list any vitamins, supplements, or over-the-counter medicines you give your child: _____ | |

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| **Child Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.** | |
|---|---|
| **My child:** | |
| Uses screens (TV/phone/tablet/computer) for 2 hours per day or less: | ☐ Yes ☐ No |
| Only views screen content chosen by me or another adult: | ☐ Yes ☐ No |
| Enjoys physical activities outdoors most days of the week: | ☐ Yes ☐ No |
| Often seems anxious, sad, or depressed, more than other children their age: | ☐ Yes ☐ No |
| Are you concerned about your child's behavior such as aggression, disrespect, conflict, or other difficult interactions with your child? | ☐ Yes ☐ No |
| **Safety** | |
| My child rides in the rear seat with booster seat for every car ride if he or she is under 4 feet 9 inches tall: | ☐ Yes ☐ No |
| We have medicines in locked cabinets: | ☐ Yes ☐ No |
| My child knows how to swim: | ☐ Yes ☐ No |
| My home has smoke detectors: | ☐ Yes ☐ No |
| My child wears a helmet when on a bicycle, scooter, or other wheeled toy: | ☐ Yes ☐ No |
| There are guns in our home or in other homes where my child visits: | ☐ Yes ☐ No ☐ I don't know |
| If Yes, are all guns stored unloaded and locked away, with ammunition locked away separately? | ☐ Yes ☐ No ☐ I don't know |
| Have you talked about safety with your child?<br>Examples include wearing helmets, privacy and safe bodies, interacting with strangers, guns, pools, emergency contact numbers, and 911, etc. | ☐ Yes ☐ No |
| An adult supervises my child's internet activities: | ☐ Yes ☐ No |
| **Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.** | |
| Have there been any major changes for your family in the past 2 years? (examples might include separation/divorce, moving to a new neighborhood, loss of family members, loss of pets). If yes, please describe _____ | ☐ Yes ☐ No |
| Do you have concerns for low mood, depression, or anxiety in yourself or your partner? | ☐ Yes ☐ No |
| Are you concerned your child has been exposed to violence, sex, or abuse? | ☐ Yes ☐ No |
| Do you have any other concerns about safety in your home? | ☐ Yes ☐ No |
| **Is there anyone who lives in your home or cares for your child who:** | |
| – Smokes or vapes tobacco or marijuana: | ☐ Yes ☐ No |
| – Uses prescription pain medication: | ☐ Yes ☐ No |
| – Uses other drugs: | ☐ Yes ☐ No |
| – Consumes alcohol more than an occasional drink (a beer or glass of wine at night): | ☐ Yes ☐ No |
| **Within the past 12 months, have you:** | |
| – Run out of food or been worried your food would run out before there was money to buy more? | ☐ Yes ☐ No |
| – Worried about housing or had to move? | ☐ Yes ☐ No |
| – Had difficulty getting other supplies and services you need to care for your child?<br>Examples would be car seat, bicycle helmet, hot water, electricity, and transportation. | ☐ Yes ☐ No |

NOT TO BE FILED IN THE MEDICAL RECORD



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