

School Age Child / 9 - 10 year check

Child's Name _____

Please have your child give a urine sample. Cups are in the bathroom.

(please circle all that apply)

Age of child _____ Grade child is in _____ Name of school _____

My child has problems in the following area(s) at school:
academics (grades) social (friends) behavioral (teachers)
no issues - things are great

My child is involved in the following sports/music/arts/dance/activities:

Screen time for my child is about _____ hours daily

My child and I disagree over his/her diet:
never sometimes daily

My child uses the following medications: _____

My child has issues with:
sleep constipation/potty

I have discussed puberty with my child:
yes no

My child has parents/grandparents with:
stroke/heart attack before age 55 high cholesterol/on cholesterol medication

My child has seen the dentist:
within the last year not lately

My child rides in:
booster seat seatbelt only the back seat the front seat

My child has seen the following specialists since our last visit: _____

My child's behavior problems are:
minimal OK with time-out and limit setting a problem

I think our family's stress level right now:
is low is pretty average is high

The insurance I have is through:
work the state health care exchange

Are there any recent or upcoming changes for the family (moves, births, etc.)?
yes no

Do you have any questions or concerns (if yes, please list on the back)