Appt Date_____ 7 year Check Up

Patient Name_____ DOB_____

Name of person filling out form _____ Phone number_____

Nutrition:

How many cups of milk does your child drink per day? _____

How many cups of juice does your child drink per day?_____

How many cups of water does your child drink per day?_____

How many cups of soda does your child drink per day?_____

Does your child eat a variety of meats, fruits, and vegetables each day?_____

Bowel/Bladder:

Any concerns about your child's voiding or stooling?_____

Sleep:

How many hours does your child sleep at night? _____

Hearing/ Vision:

Any concerns about your child's hearing or vision?_____

Social hx:

How much screen time does your child get each day? _____

What school does your child attend?_____ What grade?_____

Does your child do well in school?_____ Any concerns?_____

What activities/hobbies does your child enjoy?_____

Advice and Guidance for Parents: *(please check off as you read)*

___ Safety: Accidents remain the main cause of injury; always use seatbelts when riding in a car. Keep dangerous things like firearms and matches away from your child.

___Wear SPF 30 or greater for sun exposure

___Be sure your child brushes his/her teeth at least twice a day. You should floss and brush your child's teeth at least weekly. Regular dental exams are important.

___Smoke Exposure: Minimize your child's exposure to cigarette smoke

___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____

___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___

___Limit screen time to no more than 2 hours per day. You should not put a TV in your child's room.

___Nutrition: Your child should have at least 2 servings of dairy every day for calcium, limit sugar drinks, and encourage your child to choose nutritious foods and snacks. Packing your child's school lunch is also encouraged.

___ Sleep: Your child should have at least 10 ½ hours of sleep every night.

___ Behavior: Still use time out for one minute for every year of age.

(for podcasts on Behavior, go to www.shotshurtless.com)

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? _____