5 Year Well Check-Up

Person completing form: Mother___ Father____ Grandparent____ Other ___________

Language(s) spoken at home_________________________________

Parental Concerns:
Do you have any concerns about your child's learning development?
Not At All ○ Somewhat ○ Very Much ○

Do you have any concerns about your child's behavior?
Not At All ○ Somewhat ○ Very Much ○

Relationships:
Who lives in the home with the child?_____________________________
Number of siblings? ____________
Does your child attend daycare? No____Yes____
Are you coping well with your child? No____Yes____
Are you comfortable with your child? No____Yes____
Over the past 2 weeks, have you felt down, depressed or hopeless? No____Yes____
Are there smokers at home? No____Yes____
If yes, do they smoke outside only? No____Yes____

TB Risk Assessment:
Known exposure to person with TB? No____Yes____
If yes, who? ___________________________

Home Environment & Safety:
Type of dwelling: (circle one) Apartment House Trailer Other
Heat source: (circle one) Gas Electric Hot water Other
Water source for dwelling: (circle one) City/municipal Well
Known Lead exposure in home? No____Yes____
If yes, was it removed? No____Yes____
Home built before 1950? No____Yes____
Home built before 1978 with renovations in last 6 months? No____Yes____\

Safety:
Use bike/skating helmet? No____Yes____
Child car seat/booster seat? No____Yes____
Does your dwelling have:
Carbon monoxide detectors? No____Yes____
Smoke detectors? No____Yes____
Pool/spa at home? No____Yes____
Pets or animals at home? No____Yes____
If yes, what types? _______________________
Firearms in the home? No____Yes____
If yes, are they in locked storage? No____Yes____

Education:
School Name _____________________________ Grade _______
Learning disability diagnosed/suspected? No____Yes____
Special needs in school? No____Yes____

Activity/Exercise:
Any concerns? No____Yes____
How many hours of exercise per day? ___________
How many hours per day watching TV or playing video games? ______________________
Any organized sports/activities? No____Yes____
If yes, what types? __________________________

Sleep Habits:
Any concerns? No____Yes____
If yes, explain____
Does your child sleep alone in own room? No____Yes____
Does your child sleep 8 hrs or more per night? No____Yes____
Any nightmares? No____Yes____

Travel:
Any recent travel out of the country? No____Yes____
If yes, where did you travel? ______________________________

Nutrition:
Does your child drink (circle all that apply): Milk Juice Water Soda
What type of milk is given?
Whole ___2%___1%___Soy ___Almond ___Rice____
How many ounces of milk per day? __________
How many ounces of juice per day? __________
Does your child eat a healthy variety of table foods? No____Yes____

Dental:
Any concerns with child's teeth? ____________________________
Brushing teeth every day? No____Yes____
Regular visits to dentist every 6 months? No____Yes____
Any cavities? No____Yes____

Elimination:
Any concerns with urine output? No____Yes____
Any concerns with bowel movements? No____Yes____

Illness/Injuries/Hospitalizations/Surgeries:
Since the last well visit, has your child:
Had any injuries or admitted to the hospital? No____Yes____
Had any surgery? No____Yes____
If yes, please explain ____

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Family History:
Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe ______________________________
____

*****See Back of Form*****

Developmental Milestones

	Not At All	Somewhat	Very Much
Tells you a story from a book or tv ………	O	O	O
Draws simple shapes – like a circle or a square……………………	O	O	O
Says words like “feet” for more than one foot or “men” for more than one man ……………..	O	O	O
Uses words like “yesterday” or “tomorrow” correctly…….	O	O	O
Stays dry all night………..	O	O	O
Follows simple rules when playing a board game or card game……………..….	O	O	O
Prints his or her name….	O	O	O
Draws pictures you recognize…….	O	O	O
Stays in the lines when coloring…..	O	O	O
Names the day of the week for correct order………………….	O	O	O