# 6-10 Year Well Check-Up

**Person completing form: Mother___ Father____ Grandparent____ Other _____**
Language(s) spoken at home_____

**Parental Concerns**: Do you have any concerns today? No__Yes__
**IF YES**, please explain_____

**Relationships:**
Who lives in the home with the child?_____
Number of siblings? _____
Are you coping well with your child? No____Yes____
Are you comfortable with your child? 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____
Any home renovations in last 6 months? No____Yes____
Use bike/skating helmet? No____Yes____
Booster seat w/seatbelt in vehicle? 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 _____
Has your child repeated any grades in school? No____Yes____
If yes, what grade? _____
Average grades _____
Does your child like school? No____Yes____
Ever suspended or expelled? No____Yes____
If yes, please explain: _____
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 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____

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

**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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