

**11-12 YEAR  
PEDIATRIC DEVELOPMENTAL SCREENING**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male Female

Physician Signature: \_\_\_\_\_

Instructions: Please answer the questions below by choosing YES or NO.

<b>General Health</b>		
Do you have any concerns about your child's health?	NO	YES
Does your child receive healthcare from anyone besides a medical doctor(acupuncturist, herbalist, naturopath)?	NO	YES
<b>Nutrition</b>		
Does your child have fruits or vegetables at every meal?	YES	NO
Are you giving your child mostly whole grains?	YES	NO
Is your child drinking milk?	YES	NO
How much milk per day?		
What type of milk?		
Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
Is your child taking any vitamins or supplements?	YES	NO
Does your child drink juice, soda, energy drinks, or other sweetened drinks?	NO	YES
<b>Lipids</b>		
Have any parents or grandparents experienced a stroke or heart attack before age 55?	NO	YES
Do either parent have high cholesterol or are on cholesterol medication?	NO	YES
<b>Oral Health</b>		
Are cavities a problem for you or anyone in your family?	NO	YES
Is your child brushing their teeth twice a day and flossing once a day?	YES	NO
Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Does your child see a dentist twice per year?	YES	NO
<b>School</b>		
Does your child have problems with progress in school or ability to learn?	NO	YES
Does your child have problems with sitting still or concentrating on schoolwork?	NO	YES
Does your child have problems with the ability to get along with teachers?	NO	YES
Does your child have problems with happiness, self esteem, or self-confidence?	NO	YES
Do they have problems with irritability, temper, outbursts, or excessive anger?	NO	YES
Do they have problems with peer relationships (lack of friends, bullying)?	NO	YES
<b>Activity/Exercise/Screen time</b>		
Does your child watch more than 2 hours of screen time per day(TV, computer, video games)?	NO	YES
Is there a TV, computer, or video game system in your child's bedroom?	NO	YES
Does your child play actively at least one hour per day?	YES	NO
Do you encourage family activities such as walking, bicycling, swimming, or dancing?	YES	NO
Do you do educational activities as a family, such as go to museums, zoos, or libraries?	YES	NO
Do you eat meals together as a family?	YES	NO
Do you spend time alone with each of your children?	YES	NO
Do you spend time alone with your partner?	YES	NO

# 11-12 YEAR PEDIATRIC DEVELOPMENTAL SCREENING

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>Social Stressors</b>		
Are you able to take a little time for yourself?	YES	NO
Have you had any major changes or stresses in your family recently?	NO	YES
Do you ever worry your family will go hungry?	NO	YES
Does your partner ever hurt you or your children?	NO	YES
<b>Safety</b>		
Do you talk with your child about internet safety? Are parental controls set?	YES	NO
Do you have rules about being home alone (answering the door and phone)?	YES	NO
Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO
Is your child exposed to anyone who smokes?	NO	YES
Is there a gun in the home?	NO	YES
If yes, is it locked or in a safe place?	YES	NO
Do you use sunscreen on your child for prolonged sun exposure?	YES	NO
Does your home have working smoke detectors and carbon monoxide detectors?	YES	NO
Does your child use a seat belt? Do they sit in the back seat?	YES	NO
Do you have a home fire escape?	YES	NO
<b>Tuberculosis</b>		
Has a family member or contact had tuberculosis disease?	NO	YES
Has a family member had a positive TB skin test (PPD)?	NO	YES
Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
Has your child traveled to a high-risk country for more than a week?	NO	YES
<b>Review of Systems</b>		
<i>Any Concerns About...</i>		
Eating habits, weight loss, or lack of energy?	NO	YES
Sleep problems, including excessive snoring?	NO	YES
Eye redness, excessive tearing, or discharge?	NO	YES
Recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
Chest pain, shortness of breath, or irregular heartbeat?	NO	YES
Frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
Abdominal pain, vomiting, diarrhea, constipation?	NO	YES
Kidney or bladder problems, infections, blood in the urine?	NO	YES
Birthmarks, skin rashes, itching, nail or hair problems?	NO	YES
Joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
Recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
Mood changes, sadness, nervous problems?	NO	YES
Excessive thirst or hunger, increased urination?	NO	YES
Paleness, anemia, easy bruising, swollen glands?	NO	YES
Puberty?	NO	YES
<b>FOR FEMALES:</b>		
Has she gotten her period?	NO	YES
Problems or questions about menstruation?	NO	YES