5 YEAR
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ______________________

Name: ______________________________________ DOB:___________ Male Female

Physician Signature: ______________________________________

Instructions: Please answer the questions below about your child by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have any concerns about your child's health?	NO	YES
Any problems with previous immunizations?	NO	YES
Feeding/ Nutrition		
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 or other sweetened drinks?	NO	YES
Lipids		
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
Oral Health		
Are cavities a problem for you or anyone in your family?	NO	YES
Are you using a soft toothbrush or cloth to clean child's teeth two times 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
Elimination		
Does your child have a daily soft bowel movement (poop)?	YES	NO
School		
Is your child in preschool?	YES	NO
Do you have any concerns about learning or school behavior?	NO	YES
Activity/Exercise/Screen time		
Does your child watch more than 2 hours of screen time per day(TV, computer, video games)?	NO	YES
Is there a TV 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 read to your child every 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
Sleep		
Do you have concerns about your child's sleep?	NO	YES
Does your child snore more than a little?	NO	YES

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Social Stressors		
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
Behavior		
Do you have questions about discipline?	NO	YES
Do you praise your child when they are behaving well?	YES	NO
Do you give your child choices?	YES	NO
Development		
Does your child talk well using long meaningful sentences?	YES	NO
Does your child tell simple stories and nursery rhymes?	YES	NO
Do others fully understand your child's speech?	YES	NO
Does your child know their full name, telephone number, and 911?	YES	NO
Does your child create imaginary stories, fantasies, situations?	YES	NO
Can your child skip or hop on one foot 4-5 times?	YES	NO
Does your child know four or more colors?	YES	NO
Can your child count to ten?	YES	NO
Can they stack eight or more blocks?	YES	NO
Can they draw a person with a head, body, arms, and legs?	YES	NO
Can they copy a square?	YES	NO
Can they dress themselves without supervision?	YES	NO
Safety		
Do you talk with your child about stranger safety?	YES	NO
Does your child know that private parts are private?	YES	NO
Do you watch your child when they play outside?	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
QÁ^•ÈÁs it locked or in a safe place?	ŸÒÙ	ÞU
Does you child ride in a safety seat, in the back seat?	YES	NO
Do you use sunscreen on your child for prolonged sun exposure?	YES	NO
Do you ever leave your child alone in the car, house, or yard?	NO	YES
Does your home have working smoke detectors and carbon monoxide detectors?	YES	NO
Do you have a home fire escape?	YES	NO
Tuberculosis		
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 that the U.S., Canada, Australia, or Western Europe?	NO	YES
Has you child traveled to a high-risk country for more than a week?	NO	YES
Review of Systems		
Do you have any concerns about vision?	NO	YES
Do you have any concerns about hearing?	NO	YES

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Do you have any concerns about allergies?	NO	YES
Do you have any concerns about wheezing?	NO	YES
Do you have any concerns about frequent abdominal pain?	NO	YES
Do you have any concerns about frequent joint pain?	NO	YES
Do you have any concerns about headaches?	NO	YES
Do you have any concerns about skin or rashes?	NO	YES