KAISER PERMANENTE®

# Well-Visit Questionnaire
## Children Age 5 Years

**Your child is 5 years old!**

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

| **Do you have specific concerns? Check all that apply, then briefly describe your concern:** | |
|---|---|
| ☐ Well Visit ☐ Abdominal pain ☐ ADHD ☐ Allergies ☐ Behavior ☐ Cold/flu ☐ Constipation ☐ Cough ☐ Earache ☐ Fever ☐ Growth/nutrition ☐ Injury ☐ Learning ☐ Rash ☐ School issues ☐ Sore throat ☐ Speech ☐ Vaccines ☐ Vomiting ☐ Other (please explain):_____ Briefly describe your concern:_____ | |
| **Health Changes** | |
| Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____ | ☐ Yes ☐ No |
| Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____ | ☐ Yes ☐ No |
| **Nutrition, Feeding and Supplements – Tell us about what your child eats.** | |
| My child eats a variety of fruits and/or vegetables over the course of a week: | ☐ Yes ☐ No |
| My child has a daily source of iron in their diet, like meat or beans: | ☐ Yes ☐ No |
| Please list any other vitamins, supplements, or over-the-counter medicines you give your child: _____ | |
| **Dental Health** | |
| Does your child see a dentist twice a year? | ☐ Yes ☐ No |
| **School** | |
| What grade is your child in: ☐ Kindergarten ☐ Pre-K ☐ Other (please describe):_____ | |
| What is the name of your child's school? _____ | |
| Does your child receive educational services or accommodations (check all that apply)? ☐ No ☐ IEP ☐ 504 plan ☐ Special education ☐ Therapy (OT/PT/Speech) ☐ Other (please describe): _____ | |
| Do you have concerns about your child's learning, attention, or behavior in school? If Yes, please describe: _____ | ☐ Yes ☐ No |
| **Child Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.** | |
| **My child:** | |
| Uses full sentences and easily tells stories: | ☐ Yes ☐ No |
| Uses appropriate words for plural vs singular, and past vs present time: | ☐ Yes ☐ No |
| Knows and draws simple shapes: | ☐ Yes ☐ No |
| Can make drawings that are recognizable - when they draw people, they have at least 3 body parts or features (like eyes, mouth, arm, etc.): | ☐ Yes ☐ No |
| Knows their alphabet: | ☐ Yes ☐ No |
| Writes their name: | ☐ Yes ☐ No |


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| | |
|---|---|
| Knows at least 5 colors: | ☐ Yes ☐ No |
| Uses scissors: | ☐ Yes ☐ No |
| Has a lively imagination during play: | ☐ Yes ☐ No |
| Can dress themselves, including buttons, snaps, and front zippers: | ☐ Yes ☐ No |
| Can balance on 1 foot for 5 seconds on both sides: | ☐ Yes ☐ No |
| Uses screens (TV/phone/tablet/computer) for 2 hours per day or less: | ☐ Yes ☐ No |
| Only views screen content chosen by me or another adult: | ☐ Yes ☐ No |
| Does your family enjoy physical activities outdoors with your child? | ☐ Yes ☐ No |
| **Safety** | |
| My child rides in the rear seat with booster seat for every car ride: | ☐ Yes ☐ No |
| We have gates across stairs and safety guards on windows: | ☐ Yes ☐ No |
| We have cleaning supplies, medicines, and matches locked away: | ☐ Yes ☐ No |
| My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets): | ☐ Yes ☐ No |
| My child is learning how to swim: | ☐ Yes ☐ No |
| My home has smoke detectors: | ☐ Yes ☐ No |
| My child wears a helmet when on a bicycle, scooter, or other wheeled toy: | ☐ Yes ☐ No |
| There are guns in our home or in other homes where my child visits: | ☐ Yes ☐ No ☐ I don't know |
| If Yes, are all guns stored unloaded and locked away, with ammunition locked away separately? | ☐ Yes ☐ No ☐ I don't know |
| Have you talked about safety with your child?<br>Examples include crossing the street, talking with strangers, wearing helmets, body safety, and inappropriate touch. | ☐ Yes ☐ No |
| **Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.** | |
| Do you have concerns for low mood, depression, or anxiety in yourself or your partner? | ☐ Yes ☐ No |
| Are you concerned your child has been exposed to violence or abuse? | ☐ Yes ☐ No |
| Do you have other concerns about safety in your home? | ☐ Yes ☐ No |
| **Is there anyone who lives in your home or cares for your child who:** | |
| - Smokes or vapes tobacco or marijuana: | ☐ Yes ☐ No |
| - Uses prescription pain medication: | ☐ Yes ☐ No |
| - Uses other drugs: | ☐ Yes ☐ No |
| - Consumes alcohol more than an occasional drink (a beer or glass of wine at night): | ☐ Yes ☐ No |
| **Within the past 12 months, have you:** | |
| - Run out of food or been worried your food would run out before there was money to buy more? | ☐ Yes ☐ No |
| - Worried about housing or had to move? | ☐ Yes ☐ No |
| - Had difficulty getting other supplies and services you need to care for your child?<br>Examples would be car seat, bicycle helmet, hot water, electricity, and transportation. | ☐ Yes ☐ No |

NOT TO BE FILED IN THE MEDICAL RECORD



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