

## Well Child Care 9-10 yrs

Name :

DOB:

Date:

Do you have any concerns today ?  No  Yes \_\_\_\_\_

| Review of systems/symptoms  | yes | no | Review of systems/symptoms                               | yes | no |
|---|-----|----|--|-----|----|
| Appetite good ?   |     |    | <b>School</b> : Grade_____ . Special Education?          |     |    |
| Eats carbs, vegetables ,fruits, meat, fish ,fast foods, candy? (circle) |     |    | Social interaction normal ?                              |     |    |
| Bowel movements ?   |     |    | Performance normal?                                      |     |    |
| Urination normal ?  |     |    | Behavior normal?   |     |    |
| Any sleep concerns?   |     |    | Attention normal ?                                       |     |    |
| Any hearing problems?   |     |    | Homework normal?   |     |    |
| Any Vision Problems?  |     |    | Any school problems and/or bullying issues ?             |     |    |
| Any TB Exposure?  |     |    | After school care ?                                      |     |    |
| Any lead poisoning risks?   |     |    | <b>Home:</b> cooperation normal ?                        |     |    |
| <b>Physical activity</b> : playtime (60 min/day)                        |     |    | Parent-child interaction normal ?                        |     |    |
| Screen time (<2 hrs/day)  |     |    | Sibling interaction normal?                              |     |    |
| Immunizations up to date?   |     |    | Oppositional behavior ?                                  |     |    |
| <b>Developmental Questions :</b>  |     |    |  |     |    |
| Knows the month, day and year   |     |    | Names the months in order (in 15 sec, 1 error)           |     |    |
| Participate in after school activities?                                 |     |    | Has friends  |     |    |
| Is vigorously active for 1 hr a day                                     |     |    | Is getting chances to make own decisions ?               |     |    |
| Has a caring supportive family  |     |    | Feels good about self                                    |     |    |
| Is doing well in school   |     |    | Does an activity really well: describe _____             |     |    |
| <b>Safety/anticipatory guidance issues</b>                              |     |    |  |     |    |
| Family violence & substance abuse? circle                               |     |    | Gun safety? <input type="checkbox"/> chose not to answer |     |    |
| <b>Family history</b>   |     |    |  |     |    |
| High cholesterol ,Triglycerides   |     |    | Obesity  |     |    |
| Diabetes  |     |    | Early Heart disease ,Hypertension                        |     |    |

**Anticipatory guidance:**  discussed and /or handout given

**School :**  show interest in school  Quiet space for homework  Address bullying

**Development & Mental Health:**  Encourage independence and self-responsibility  Be a positive role model -discuss respect, anger  discuss expected body changes  Know child's friends and importance of peers  Expect preadolescent behavior  Answer questions and discuss puberty  Safety rules with adults

**Nutrition & physical activity:**  Encourage proper nutrition & healthy weight  Eat meals as a family  60 min of exercise/day  Limit TV & screen time

**Oral health:**  Dentist visits 2x /yr  Brush twice a day  Floss teeth daily  Wear mouth guard during sports

**Safety**  Appropriate vehicle restraint  Teach to swim /water safety  Avoid tobacco, alcohol, drugs  Sun Screen  Guns

**For Providers:** fasting lipid age 2-10 if any of above risk factors.

Signature of parent/guardian:

Provider signature: