

Parent / Guardian Questionnaire (5-6 year old)

Pediatric Specialists of the Northwest

Child's name: _____ Date of birth: _____ Date completed: _____

Your name: _____ Relation to child: _____

Check, circle, or complete all of which apply to your child

DAILY ACTIVITY and ROUTINE	NUTRITION and BOWEL HABITS
<p>Year in school (if applicable) or going into:</p> <p><input type="checkbox"/> Preschool <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1st Grade</p> <p>Services my child receives</p> <p><input type="checkbox"/> Repeated any grade <input type="checkbox"/> Special education <input type="checkbox"/> IEP</p> <p><input type="checkbox"/> Speech therapy <input type="checkbox"/> OT <input type="checkbox"/> PT</p> <p>My child:</p> <p>Reads / I read to my child _____ minutes / day</p> <p>Writes / draws YES or NO</p> <p>Plays with friends YES or NO</p> <p>Screen time (unrelated to homework) _____ hrs / day (i.e. TV, video games, computer)</p> <p>Phone/texting/use of social media _____ hrs / day</p> <p>Goes to bed inconsistently / consistently at _____ pm</p> <p>Gets _____ hours of sleep <i>on average</i> each night</p> <p>Playtime _____ hrs / day</p>	<p>Daily intake:</p> <p>Dairy (mil, yogurt, cheese, other) _____ servings / day</p> <p>Meat, poultry, fish, eggs & nuts _____ servings / day</p> <p>Vegetables _____ servings / day</p> <p>Fruits _____ servings / day</p> <p>Bread, cereal, rice & pasta _____ servings / day</p> <p>Supplement: <input type="checkbox"/> vitamin <input type="checkbox"/> iron <input type="checkbox"/> Other _____</p> <p>Soda or pop _____ oz / day Juice _____ oz / day</p> <p>Fast food _____ times / week Junk food _____ times / day</p> <p>Concerns about bowel movements / urination <input type="checkbox"/> No <input type="checkbox"/> Yes</p>

SOCIAL HISTORY	
<p>In the past year, have there been any changes or challenges in your family?</p> <p><input type="checkbox"/> Marriage <input type="checkbox"/> Loss of job <input type="checkbox"/> Births</p> <p><input type="checkbox"/> Separation <input type="checkbox"/> Move to a new neighborhood <input type="checkbox"/> Serious illness</p> <p><input type="checkbox"/> Divorce <input type="checkbox"/> Deaths</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p> <p><input type="checkbox"/> No interval changes</p>	
Does your child live with or spend time with anyone who uses tobacco or smokes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child play with other children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child say "I'm sorry" for hurting someone's feelings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have reason to suspect that your child is bullied or bullying?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you know what signs to look for if your child is being bullied?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do new people understand your child's speech?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Reviewed and discussed by _____, MD/DO Date: _____

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Your name: _____ Relation to child: _____

FAMILY HISTORY

Have you or any of your child's relatives developed new medical problems since your last visit? No Yes

Check all that apply

HOW WOULD YOU BEST DESCRIBE YOUR CHILD

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Quiet, Timid | <input type="checkbox"/> Short attention | <input type="checkbox"/> Poor self-control |
| <input type="checkbox"/> Active | <input type="checkbox"/> Sad | <input type="checkbox"/> Cries easily | <input type="checkbox"/> Distracts easily | <input type="checkbox"/> Initiates physical fights |
| <input type="checkbox"/> Pays attention | <input type="checkbox"/> Tired, Fatigue | <input type="checkbox"/> Fears new situations | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Vandalizes / destroys property |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Cruel to people or animals | | |
| <input type="checkbox"/> Speech delay | <input type="checkbox"/> Sleep problems | | <input type="checkbox"/> Stereotypic habit | |
| <input type="checkbox"/> Social communication delay | <input type="checkbox"/> Temper tantrums | | Nail biting, thumb sucking, hair pulling | |
| <input type="checkbox"/> Poor eye to eye contact | <input type="checkbox"/> Separation anxiety | | Head banging, body rocking | |
| <input type="checkbox"/> Does not play with other kids | <input type="checkbox"/> Difficult toilet training | | <input type="checkbox"/> Other concern: | |

Lead Risk Assessment – Circle the appropriate response

- | | | | |
|---|-----|----|------------|
| 1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? | YES | NO | DON'T KNOW |
| 2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher? | YES | NO | DON'T KNOW |
| 3. Does this child live in or regularly visit a home built before 1978? | YES | NO | DON'T KNOW |
| 4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? | YES | NO | DON'T KNOW |
| 5. Is this child a refugee or an adoptee from any foreign country? | YES | NO | DON'T KNOW |
| 6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e. China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? | YES | NO | DON'T KNOW |
| 7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | YES | NO | DON'T KNOW |
| 8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? | YES | NO | DON'T KNOW |
| 9. Does this child reside in a high-risk zip code area? (see attached table of zip codes) | YES | NO | DON'T KNOW |

Tuberculosis Assessment – Circle the appropriate response

- | | | | |
|--|-----|----|------------|
| 1. Was your child born in a country/continent at high risk for tuberculosis? | YES | NO | DON'T KNOW |
| 2. Has your child traveled for longer than 1 week to Africa, Asia, Latin America, or Eastern Europe? | YES | NO | DON'T KNOW |
| 3. Has a family member or contact had tuberculosis or a positive tuberculin skin test? | YES | NO | DON'T KNOW |
| 4. Does your child spend any time with anyone who has been in jail, uses illegal drugs, or has HIV? | YES | NO | DON'T KNOW |

If you have additional questions or concerns, please list them on a separate sheet.

Reviewed and discussed by _____, MD/DO Date: _____

**Illinois Department of Public Health
High Risk Zip Codes for Pediatric Lead Assessment
by County**

County	Zip Code	County	Zip Code
Boone	61038	DeKalb	60111
			60129
Cook	All Chicago zip codes		60146
	60043		60550
	60104	DuPage	60519
	60153		
	60201	Kane	60120
	60202		60505
	60301		
	60302	Kendall	None
	60304		
	60305	Lake	60040
	60402		
	60406	McHenry	60034
	60456		
	60501	Will	60432
	60513		60433
	60534		60436
	60546		
	60804		