Child's Name: _____ Date: _____ MD/NP _____

4 YEAR OLD PARENT SURVEY

LEARNING/DEVELOPMENT

What are your child's strengths? _____

_____

Has preschool gone well for your child?	NA	N	Y
Do you have concerns about your child's learning?		Y	N
Do you read to your child for ≥20 minutes daily?		N	Y
Does your child recognize some letters?		N	Y
Does your child know the letters in his/her name?		N	Y
Does any family member have dyslexia or difficulty learning how to read? If so, who? _____		Y	N

SOCIAL/EMOTIONAL

Does your child have friends/play with other kids?	N	Y
Is your child shy or does your child avoid talking with other adults or children when in a school setting?	Y	N
Does your child have a high-needs temperament?	Y	N
Do you have concerns about your child's relationship with his/her siblings?	Y	N

DIET

Do you have concerns about your child's diet?		Y		N
Are you worried about your child's BMI?	Yes	Somewhat		No
What kind of milk does your child drink	Skim	1%	2%	whole
How many ounces each day? _____				

Does your child:

eat 5 (or more) servings of fruits/vegetables daily?	N	Y
have carbohydrates as the main part of his/her diet?	Y	N
eat foods with whole grains and fiber?	N	Y
eat 3 (or more) servings of dairy daily?	N	Y
drink sugared soda, juice, or sports drinks regularly?	Y	N
eat breakfast daily?	N	Y
eat more than 2 snacks a day?	Y	N
eat "fast food" one or more times weekly?	Y	N
eat meals together as a family ("family meals")?	N	Y
eat after dinner or before bedtime (ie: dessert)?	Y	N
get physical activity on a daily basis?	N	Y

Would you like some literature on diet for children? Y N

DENTAL HEALTH

Does your child see a dentist every 6 months?		N		Y
How many times daily does your child brush his or her teeth?	0	1	2	>2
Do you help your child brush?		N		Y
Do you floss your child's teeth at least once a day?		N		Y
Is there fluoride in the water that your child drinks at home?	Don't know	N		Y

HEALTH OF FAMILY

Who lives with your child? _____

Are there any significant marital, health, financial or employment stresses at home?	Y	N
If yes, please explain (if you would like) _____		
Are you: married partnered separated divorced single widowed other		
Do you or your partner have depression or anxiety?	Y	N
Has there been any change in employment status (new Job or lost job) for you or your partner in the last year?	Y	N
Do you have enough support with childcare?	N	Y
Does anyone in your household use tobacco?	Y	N
If yes, would you like information on quitting?	Y	N
Does anyone in your house have issues with alcohol/drugs?	Y	N
Do you feel safe in your own home?	N	Y

ELIMINATION

Do you have concerns about your child's toileting habits?	Y	N
Is your child potty trained during the day?	N	Y
Does your child routinely have constipation or diarrhea?	Y	N
Does your child have bowel accidents?	Y	N

SLEEP

Do you have concerns about your child's sleep?		Y	N
Where does your child sleep?	parent's bed	child's bed	other
Does your child sleep through the night?		N	Y
Does your child snore?		Y	N

SAFETY

How much "screen time" does your child have? _____

Has your child had any injuries this past year?	Y	N
Is your child in a car seat (or booster seat if >40 pounds)?	N	Y
Does your child always wear a helmet when riding a bike, tricycle, or scooter?	N	Y
Is there a swimming pool at or near your home?	Y	N
Is there a gun in your home?	Y	N

HEALTH CARE MAINTENANCE

Has your child travelled outside the country this year?	Y	N
Has your child been hospitalized or had surgery this year?	Y	N
Has your child been to an ER or specialist this year?	Y	N

Do you have any questions about your child for today's visit?

1. _____
2. _____

If you smoke and want to quit ……..1-800-TRY-TO-STOP
If you feel you have an alcohol problem contact Alcoholics Anonymous……1-800-443-9484
National Suicide Prevention Hotline number……..1-800-273-8255

May, 2014

Remember to check smoke detector/carbon monoxide detector batteries every 6 months.

PLEASE TURN OVER AND COMPLETE BOTH SIDES!!!!

Westwood-Mansfield Pediatric Associates

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Fax (781) 251-0910

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Fax (508) 452-3898

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115 Main Street
Easton, MA 02356
(508) 535-5535
Fax (508) 238-1315

www.wmpeds.com

Pediatric System Checklist – 17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____
Name of Child: _____

		Please mark under the heading that best fits your child		
		Never	**Sometimes**	**Often**
1	Feels sad, unhappy			
2	Feels hopeless			
3	Is down on him or herself			
4	Worries a lot			
5	Seems to be having less fun			
6	Fidgety, unable to sit still			
7	Daydreams too much			
8	Distracted easily			
9	Has trouble concentrating			
10	Acts as if driven by a motor			
11	Fights with other children			
12	Does not listen to rules			
13	Does not understand other people's feelings			
14	Teases others			
15	Blames others for his or her troubles			
16	Refuses to share			
17	Takes things that do not belong to him or her			

Does your child have any emotional or behavioral problems for which she/he needs help?

_____No _____Yes _____Already receiving help