UW Medicine
UW NEIGHBORHOOD CLINICS

6 Year Old Well Child Visit

Child's Name________________________________Child's Age __________Date:_______________

Person completing the form________________________________Relationship to the patient_______________________

Has your child had any illnesses, hospitalizations or surgeries since last visit here? (YES) (NO)

Nutrition:	Yes	No
Is your child drinking low-fat milk, limited to no more than 2-3 cups per day?	( )	( )
Is juice /sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child take a supplement that contains vitamin D regularly?	( )	( )
On average, do you eat fast food one or more times per week?	( )	( )

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illnesses, moves, death, and separation?	( )	( )

Preventative Health/Risk Factors:	Yes	No
Is screen time (TV time/video games/computer/tablet/phone) limited to less than 2 hours per day?	( )	( )
Does your child have a TV or internet in the bedroom?	( )	( )
Does your child always ride in a car seat in the back seat?	( )	( )
Do you, anyone who cares for your child, or anyone in the home smoke?	( )	( )
Does your child wear a helmet when riding a bike, skateboarding, rollerblading, etc.?	( )	( )
Are there guns in the home? And if so, are they always kept empty and locked?	( )	( )
Are there smoke detectors and fire extinguishers in the home and are they checked yearly?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB) or is at high risk for TB (visited Africa, Asia, Latin American, Caribbean country, been homeless or jailed, IV drug user, HIV positive)?	( )	( )
Does your child see a dentist twice a year and brush teeth daily?	( )	( )
Is your child getting exercise?	( )	( )

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well without snoring?	( )	( )
Does your child wet the bed regularly?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )

Developmental Surveillance:

Motor:	Yes	No
Balances on one foot?	( )	( )
Hops and skips?	( )	( )
Able to tie a knot?	( )	( )
Language:		
Can tell a story with full sentences?	( )	( )

Learning:		
Draws person (6+body parts)?	( )	( )
Prints some letters and numbers?	( )	( )
Copies squares and triangles?	( )	( )
Counts to 10?	( )	( )
Names 4 or more colors?	( )	( )
Follows simple directions?	( )	( )
Listens well?	( )	( )