The Smarter Choice for Care

Middlesex Health



5 Year Well-Child Visit
Pre-Appointment Paperwork

Please complete the following forms prior to your child's upcoming well-child visit. All forms are fillable PDFs that can be completed on your computer/smartphone, or you can print this packet and fill it in by hand.

If you are coming to our office, please bring these forms to the appointment.

If you have scheduled a virtual visit, please email the completed forms to your provider's office. Provider emails are available at middlesexhealth.org/wellchild.

We look forward to seeing you soon!

SWYC™: 60 months

59 months, 0 days to 65 months, 31 days
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Tells you a story from a book or tv	○	○	○
Draws simple shapes - like a circle or a square	○	○	○
Says words like "feet" for more than one foot and "men" for more than one man	○	○	○
Uses words like "yesterday" and "tomorrow" correctly	○	○	○
Stays dry all night	○	○	○
Follows simple rules when playing a board game or card game	○	○	○
Prints his or her name	○	○	○
Draws pictures you recognize	○	○	○
Stays in the lines when coloring	○	○	○
Names the days of the week in the correct order	○	○	○

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	○	○	○
	Seem sad or unhappy?	○	○	○
	Get upset if things are not done in a certain way?	○	○	○
	Have a hard time with change?	○	○	○
	Have trouble playing with other children?	○	○	○
	Break things on purpose?	○	○	○
	Fight with other children?	○	○	○
	Have trouble paying attention?	○	○	○
	Have a hard time calming down?	○	○	○
	Have trouble staying with one activity?	○	○	○
Is your child…	Aggressive?	○	○	○
	Fidgety or unable to sit still?	○	○	○
	Angry?	○	○	○
Is it hard to…	Take your child out in public?	○	○	○
	Comfort your child?	○	○	○
	Know what your child needs?	○	○	○
	Keep your child on a schedule or routine?	○	○	○
	Get your child to obey you?	○	○	○

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	○	○
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	○	○
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	○	○
4 Has a family member's drinking or drug use ever had a bad effect on your child?	○	○

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	○	○	○	○
7 Feeling down, depressed, or hopeless?	○	○	○	○

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)

5.2.1.0. Healthy Habits Questionnaire (Ages 2-10)

We are interested in the well-being of all of our patients. Please take a moment to answer the following questions:

CHILD'S NAME: **CHILD'S DOB:** **TODAY'S DATE:**

OVERALL ON A SCALE FROM 1-10 how would you rate your child's health? (1 = Poor, 10 = Excellent)?

1 ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯ **6** ◯ **7** ◯ **8** ◯ **9** ◯ **10** ◯

1. **FRUITS AND VEGGIES:**
   Does your child eat 5 servings of fruits and vegetables per day? **YES** ◯ **NO** ◯

2. **SUGARY DRINKS/JUICE:**
   Does your child drink juice, sports drinks, iced tea, lemonade, sweetened beverages most days? **YES** ◯ **NO** ◯

3. **SCREEN TIME:**
   Does your child watch more than 2 hours per day of TV, movies, videos, tablets, or phone? **YES** ◯ **NO** ◯

4. **EXERCISE:**
   Does your child spend at least 1 hour per day actively playing or exercising (sweating)? **YES** ◯ **NO** ◯

5. **SNACKS:**
   How many times per day does your child eat snack food (kid's yogurts, pouches, pretzels, goldfish, gummy snacks, crackers, cookies, chips)?

   1 ◯ **2** ◯ **3** ◯ **4 or more** ◯

6. **Based on your answers, is there <u>ONE</u> thing you would like to help your child change now? Please check one box.**

   ☐ Eat more fruits and vegetables ☐ Watch less screen time ☐ Eat less snack foods

   ☐ Drink more water ☐ Exercise more ☐ Less juice or soda

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Careqiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Middlesex Health

Parent Questions for Children - Stressful Events

Stressful events like trouble getting food, violence, or loss are common and can affect your child's health and development. To provide the best care, we ask all families about their experiences.

You may choose to answer these questions or not.

Child's Name: **Child's DOB:**

1. Has anyone hurt or frightened you or your child recently or in the last year?

   ○ Yes
   ○ No

2. Has anything bad, sad or scary happened to your child recently or in the last year?

   ○ Yes
   ○ No