

F. Diet: Does your child eat / drink:

Breast milk / 1%, 2%, chocolate, strawberry, whole milk / formula? How many times / day? _____
Juice (which kind? _____) How many times / day? _____
Water - tap / bottled, no fluoride / bottled with fluoride (circle those used) How many times / day? _____
Soda (which kinds? _____) How many times / day? _____
Meats / eggs / beans / poultry / fish / peanut butter (circle those eaten) How many times / day? _____
Vegetables - which ones? _____ How many times / day? _____
Fruits - which ones? _____ How many times / day? _____
Breads / cereals - which ones? _____ How many times / day? _____
How many times a week do you eat "fast food" or "eat out"? _____
Does your family or child have any special diets or food preferences?Yes No
If yes, please describe _____

G. Development / Education: What school does your child attend? _____ Grade _____

Achievement: A's B's C's D's F's Outstanding / Satisfactory / Unsatisfactory Honor Roll / Merit Roll

Do you have concerns that your child's development is not normal?Yes No
speech development coordination writing/drawing social skills bullying
School performance: math science social studies writing

H. Has your child ever participated in: (Circle all that apply)

Clubs After school sports Bilingual programs Emotional support Day care
Learning support Gifted/Talented programs Speech therapy Headstart / Evenstart Life skill class'
Special education program Organized activity (sports, scouts, leagues, etc)

J. Habits:

Does your child ever wet the bed or their pants - nighttime or daytime?Yes No
Does your child soil their pants - daytime or nighttime?Yes No
Do you read with your child every day for at least 30 minutes?Yes No
What is your bedtime routine with your child? _____

K. Health / fitness:

How many TVs ___ VCRs ___ DVD players___ Computers ___ are there in your home? In child's bedroom? _____
How much "screen time" does your child have daily (TV, VCR, DVD, computer games, internet access)? _____ hrs
Does your child leave on light, music, or TV when they sleep? Yes No
Do they cough, snore, or have breathing difficulty at night?Yes No
Do you know anyone who smokes cigarettes?Yes No
uses marijuana, cocaine, heroin, or other illegal substances?Yes No
What does your child do for exercise? _____
What weekend activities does your child participate in? _____
What activities do you enjoy as a family? _____

