RISK QUESTINNAIRES: 3-5 YEARS OLD

Patient Name _____Date of Birth_____Completed by_____

MENTAL HEALTH QUESTIONNAIRE
Ages 3 – 5 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often wet or soil his pants? ……..
☐ Yes ☐ No
Does your child have problems at day care or school? ……
☐ Yes ☐ No
Do you have any concerns about your child:
Daydreaming …… ☐ Yes ☐ No
Paying attention …… ☐ Yes ☐ No
Sitting still …… ☐ Yes ☐ No
Does your child:
Refuse to obey ……. ☐ Yes ☐ No
Refuse to play with others …… ☐ Yes ☐ No
Does your child get tired easily? …… ☐ Yes ☐ No
Does your child often seem:
Sad …… ☐ Yes ☐ No
Angry …… ☐ Yes ☐ No
Nervous or afraid …… ☐ Yes ☐ No
Cranky …… ☐ Yes ☐ No
Not interested …… ☐ Yes ☐ No
Does your child have trouble sleeping? …… ☐ Yes ☐ No
Does your child have problems with eating? …… ☐ Yes ☐ No
Is your child often mean to animals or smaller children? …… ☐ Yes ☐ No
Is there a history of injuries, accidents? …… ☐ Yes ☐ No
If yes, please specify:
_____
Is there any history of maltreatment or abuse? …… ☐ Yes ☐ No
If yes, please specify:
_____
Is there a recent stress on the family or child such as:
Birth of a child …… ☐ Yes ☐ No
Moving …… ☐ Yes ☐ No
Divorce or separation …… ☐ Yes ☐ NO
Death of a close relative …… ☐ Yes ☐ No
Fired or laid off …… ☐ Yes ☐ No
Legal problems …… ☐ Yes ☐ No
Others (Please specify): _____ ☐ Yes ☐ No

Do you have other parenting concerns? …… ☐ Yes ☐ No

Please specify:
_____

Provider: Give details of all **Positive** findings:

LEAD RISK QUESTIONNAIRE

1. Has your child ever lived or stayed in a house or apartment that is more than built before 1978? (includes day care center, preschool home, home of babysitter or relative) YES NO
2. Is anyone in the home being treated or followed for lead poisoning? YES NO
3. Are there any current renovations or peeling paint in a home that your child regularly visits? YES NO
4. Does your child lick, eat or chew things that are not food? (paint chips, dirt, railings, poles, furniture, old toys, etc.) YES NO
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.) YES NO
6. Your zip code ?_____ Risk area? ……. … YES NO

See page 2 for other zip codes

(A "yes" or "don't know" response to any question indicates a positive risk)

TUBERCULOSIS RISK ASSESSMENT: at age 1 then annually

1. Has your child been exposed to anyone with a case of TB? YES NO
2. Was your child, or a household member, born in an area where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)? YES NO
3. Has your child, or a household member, lived more than a year in an area where TB is common? YES NO
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? YES NO
5. Does your child have HIV infection? YES NO

(A "yes" response to any question indicates a positive risk)

Heart Disease/Cholesterol Risk Assessment:

(2 years through 20 years)

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death? YES NO
2. Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher) YES NO

(A "yes" response to either question 1 or 2 indicates a positive risk.) YES NO

3. Is the child/adolescent overweight? YES NO
4. And is there also a personal history of:
   - Smoking? YES NO
   - Lack of physical activity? YES NO
   - High blood pressure? YES NO
   - High cholesterol? YES NO
   - Diabetes mellitus? YES NO