

Please print.

6 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence (Bullying and Fighting)		
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever been bullied or hurt physically by someone?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever bullied or been aggressive with others?	<input type="radio"/> No	<input type="radio"/> Yes
Food Security		
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
Alcohol and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Yes
Emotional Security and Self-esteem		
Does your child usually seem happy?	<input type="radio"/> Yes	<input type="radio"/> No
Are there things your child is really good at doing or is proud of?	<input type="radio"/> Yes	<input type="radio"/> No
Connectedness With Family		
Does your family get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> No

FAMILY RULES AND ROUTINES

Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> No
When your child breaks the rules, are you consistent with consequences and discipline?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child know when she is being good?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have problems dealing with angry feelings?	<input type="radio"/> No	<input type="radio"/> Yes
Do you help your child control his anger?	<input type="radio"/> Yes	<input type="radio"/> No

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SCHOOL

Did your child attend a preschool program?	<input type="radio"/> Yes	<input type="radio"/> No
Has your child started elementary school?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any concerns about your child's school experience?	<input type="radio"/> NA	<input type="radio"/> No <input type="radio"/> Yes
Are you able to attend activities or functions at your child's school?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No
Is your child involved in after-school activities?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No
Does your child receive any special education services?	<input type="radio"/> No	<input type="radio"/> Yes

STAYING HEALTHY

Healthy Teeth		
Does your child brush his teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> No
Nutrition		
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	<input type="radio"/> No	<input type="radio"/> Yes
Does your child drink soda, juice, or other sweetened drinks?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child eat breakfast every day?	<input type="radio"/> Yes	<input type="radio"/> No
Physical Activity		
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in his bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have trouble going to sleep or does he wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes

SAFETY

Car Safety		
Does your child always use a car safety seat or belt-positioning booster seat securely fastened in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the vehicle always wear a lap and shoulder seat belt or belt-positioning booster seat?	<input type="radio"/> Yes	<input type="radio"/> No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know how to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know to always have an adult watching him in the water and never to swim alone?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child use sunscreen when playing outside?	<input type="radio"/> Yes	<input type="radio"/> No
Home Fire Safety		
Do you have working smoke alarms installed on every level of your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have carbon monoxide detectors/alarms in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have an emergency escape plan in case of a fire?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know what to do if the fire alarm rings?	<input type="radio"/> Yes	<input type="radio"/> No

6 YEAR VISIT

SAFETY (CONTINUED)

Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> No

SAFETY

Harm From Adults		
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know that it is never OK for an older child or an adult to ask to see his private parts?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*

For more information, go to <https://brightfutures.aap.org>.

