Your Child's 6 Year Well Visit – What to Expect, What to Ask

Your Name: _____ Your Relationship to the Child: _____
Are there specific concerns you want to discuss today? □ No □ Yes _____

Have there been any major changes in your family lately? □ None □ Move □ Job Change □ Separation □ Divorce
□ Death in the family □ New pet □ Other? Describe: _____

Child lives with? □ Both Parents □ Mother □ Father □ Stepparent □ Grandparent(s) □ Other? _____
Total number of adults living in home: _____ Total number of children living in home: _____

Who takes care of your child most days of the week?
□ Mother □ Father □ Other relative (e.g. grandmother) □ Daycare □ Other? Describe: _____

In general, how well do you feel you are coping with the day-to-day demands of parenthood?
□ Not well at all □ Not very well □ Somewhat well □ Well □ Very well

General Health Information: Since Your Last Visit	**Yes**	**No**	**Unsure**
Have you or your child had any major illness and/or hospitalizations?			
Have you, anyone in your family, or your child's relatives developed new medical problems?			
Does your child have allergies? If yes, describe:			
Does your child take medications regularly? If yes, list here:			
Do you have someone you can trust and go to for emotional support?			
Are yours and your child's immunizations (includes flu and pneumonia) current?			
Do you or any adults around your child smoke (includes inside or outside the house)?			

Would you like to get more information on any of the topics below?

Injury Prevention	**Health Promotion**	**Behavior**	**Nutrition**
• Seat belt/auto safety	• Limit TV viewing	• Substance abuse	• Healthy diet/snacks
• Bicycles/ATV	• Passive smoking	• Tobacco use	• Junk Food
• Athletics	• Sleep patterns	• Security	• Iron-rich foods
• Water safety	• Pubertal changes/sexuality	• Discipline patterns	• Healthy weight
• Smoke detectors	• Dental care/sealants	• Social interaction	
• Firearm safety		• Responsibility	
		• Sex education	

Do you have any specific concerns about your child's learning, development or behavior? □ A lot □ A little □ Not at all
Describe: _____

Do you have any concerns about your child's vision (how well your child sees)? □ Yes □ No

Do you have any concerns about your child's hearing? □Yes □ No

Please check each task your child is able to do right now.

□ Shower/Baths with a little assistance □ Playing fair □ Fix cold cereal □ Age appropriate chores

What to expect at your Child's Texas Health Steps exam

□ Height & Weight □ Dental Referral □ Blood Pressure □ Vision & Hearing Screening □ Unclothed Physical Exam; Health History
□ Lab tests – anemia & blood questions □ Immunizations (possibly DTaP, Polio, MMR, Varicella, Hepatitis A, Pneumococcal, Meninogococcal & Influenza)

This is not a self-diagnosis tool or a treatment plan. Please consult your doctor and share this form at your next visit.