Bright Futures Parent Supplemental Questionnaire 4 Year Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please circle Yes or No for each question. Thank you.

Getting Ready for School: School Readiness

Do you answer your child's questions with short and simple answers?	Yes	No
Do you help your child say "I'm sorry" for hurting other's feelings?	Yes	No
Is your child interested in other children?	Yes	No
Does your child have a best friend?	Yes	No
Does your child have a chance to play with other children in playgroups or at preschool?	Yes	No
On most days, does your child seem happy to go to preschool or child care?	Yes	No
Do you read and play rhyming games with your child?	Yes	No
Do you take your child on trips to the park or visits to the library?	Yes	No
Does your child go to preschool?	Yes	No
Do new people understand your child's speech?	Yes	No
Do you give your child plenty of time to answer questions and tell stories?	Yes	No

Healthy Habits: Developing Healthy Personal Habits

Does your child brush his teeth twice a day?	Yes	No
Does your child nap most days?	Yes	No
Do you watch TV during meals?	No	Yes

TV and Media: Television and Media

Does your child watch TV more than 2 hours per day?	No	Yes
Does your child have a TV in her bedroom?	No	Yes
Does your child play actively for at least one hour per day?	Yes	No
Are you physically active together as a family, like going on walks or playing in the park?	Yes	No

Your Community: Child and Family Involvement and Safety in the Community

Do you need help finding community resources your family needs?	No	Yes
Do feel safe in your community?	Yes	No
Do you always feel safe in your home?	Yes	No
Do you feel comfortable answering questions your child asks about his body?	Yes	No
Does your child know that is it never OK for an older child or adult ask to see her private parts?	Yes	No

Safety

Do you always use a car safety seat or a booster seat in the back seat of the car?		Yes	No
Do you make sure to never leave your child alone in the car, house, or yard?		Yes	No
Do you watch your child closely when he plays near streets or driveways?		Yes	No
Do you keep medications, cleaning solutions, and insecticides locked up?		Yes	No
Do you know how to get help if you don't feel safe in your home?		Yes	No
Does anyone in your home or the homes where your child spends time have a gun?		No	Yes
If so, are the guns unloaded and locked away with the ammunition locked seperately from the gun?	N/A	Yes	No
Do you ask if there are guns in homes where your child plays?		Yes	No
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to quit?		Yes	No