

# Cornerstone Well Child Form – 6 Years

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parents, please take a few minutes to answer the following questions ...

## Nutrition

### Calcium Intake

- Cow's milk                       \_\_\_\_\_ Milk                       Cheese                       Calcium supplement  
 Soy milk                       Fortified juice                       Yogurt

### Total servings of calcium daily

- None                       1                       2                       3                       4 or more

### Other Food/Drink

- 3 meals/day                       Sufficient Fruit                       Drinks Juice \_\_\_\_\_ oz/day  
 1-2 healthy snacks                       Sufficient Protein                       Drinks Soda  
 Vegetarian Diet                       Sufficient Vegetables                       Too much junk food

### Dietary Supplements

- None                       Yes: \_\_\_\_\_

## Sleep Concerns

- None  
 Sleeping too long                       Child snores                       Night waking  
 Difficulty falling asleep                       Nighttime wandering  
 Decreased need for sleep                       Nightmares

## Activity Levels

- Physical Activity                      \_\_\_\_\_ Min(s)/day                      \_\_\_\_\_ Time(s)/week                       None  
Screen Time                      \_\_\_\_\_ Hours/day - TV                      \_\_\_\_\_ Hours/day – Computer                       None

## School

- \_\_\_\_\_ Grade level  
 Public school                       Private school                       Home school                       Cyber school

Special Education needs: \_\_\_\_\_

- Performance                       Excellent                       Good                       Fair                       Poor

## Developmental Milestones

- Laces, ties shoes                       Gets along with family  
 Healthy meals, snacks                       Appropriate behavior at school  
 Active >1 hour daily                       Does assigned chores  
 Rides a bicycle                       Has friends  
 After school activity

Other Development Concerns:  None                       Yes: \_\_\_\_\_

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## For Office Use Only

Weight: \_\_\_\_\_                      Pulse: \_\_\_\_\_                      BP: \_\_\_\_\_

Length: \_\_\_\_\_                      Temp: \_\_\_\_\_                      Hearing: \_\_\_\_\_

Vision: Both 20/\_\_\_\_                      Right 20/\_\_\_\_                      Left 20/\_\_\_\_                      Glasses/Contacts