Finnish Institute for Health and Welfare

Background information questionnaire for a health examination for a four-year-old child's parents

Basic information on the child and the family

Child's first name	Child's last name
Child's personal identity code	Child's mother tongues
Other languages spoken in the family ☐ Finnish ☐ Swedish ☐ Sámi ☐ other, please specify (need for an interpreter) _____	

Parents'/guardians' information

First name	Last name
Telephone number where you can be reached during the day	
First name	Last name
Telephone number where you can be reached during the day	

Child's family

The child lives	
☐ with both parents only	☐ with the other parent sometimes
☐ mainly with one of the parent	☐ never with the other parent
☐ with the other parent 50% of the time	☐ other living arrangement
Who has custody of the child?	
Changes in the family structure	
☐ no changes	☐ other, please specify
☐ separation/divorce	_____
☐ new relationship/marriage	
Meeting and alternating residence arrangements if parents live separately	
Does your child have biological siblings? ☐ No ☐ Yes, how many? _____	Does your child have other siblings? ☐ No ☐ Yes, how many? _____
Siblings' names and years of birth?	
Other persons belonging to the family or the same household	

Child's early childhood education and care

Does your child participate in early childhood education and care?			
☐ No	☐ yes, where?	☐ day care activities	☐ family day care
		☐ group family day care	☐ other arrangement
How many hours per day/week does your child attend early childhood education and care?			

Child's health and wellbeing

Are you concerned about your child's health?
☐ No ☐ Yes, why? _____

Does your child have any long-term symptoms, illnesses or injuries?
☐ No ☐ Yes, please specify _____

Does your child continuously or occasionally use any medicines?
☐ No ☐ Yes, please specify _____

Does your child have any allergies?
☐ No ☐ Yes, please specify _____

Does your child have a special diet?
☐ No ☐ Yes, which of the following?

☐ lactose-free or low-lactose diet
☐ gluten-free diet
☐ vegetarian diet including dairy products and/or eggs
☐ vegetarian diet including fish
☐ vegan diet
☐ grain allergy diet
☐ milk allergy diet
☐ other diet due to a food allergy
☐ other special diet

If your child has a diagnosed illness, where is their illness treated?

Has your child repeatedly had any of the following symptoms?

☐ abdominal problems/constipation
☐ skin rash
☐ prolonged cough (more than 2 months)
☐ prolonged head cold (more than 2 months)
☐ other symptoms, ailments or pains

Has your child been in an accident requiring a visit to a physician, public health nurse or nurse?
☐ No ☐ Yes, please specify _____

Do you think your home is safe for children?
☐ Yes ☐ No

Do you think the area surrounding your home is safe for children?
☐ Yes ☐ No

What kind of potential safety risks have you identified in your child's living environment?

Please describe your child's nature

Have you noticed any behaviour that worries you?
☐ No ☐ If yes, what?

Parent's/guardian's opinion on the child's development

Does your child like to walk, run or jump cheerfully?
☐ Yes ☐ No

Does your child like to play different games?
☐ Yes ☐ No

What kind of games does your child play and with whom?

Is your child's speech clear and understandable?
☐ Yes ☐ No

Do you read books with your child?
☐ Yes ☐ No

Does your child like drawing and crafts? ☐ Yes ☐ No	Does your child eat different types of food independently? ☐ Yes ☐ No
Has your child made friends with other children? ☐ Yes ☐ No	Can your child take other children into consideration well? ☐ Yes ☐ No
Does your child recognise the need to go the toilet on their own? ☐ Yes ☐ No	Does your child wet the bed? ☐ Yes ☐ No
Are there any illnesses, developmental delays or learning difficulties in your family (parents, grandparents, biological siblings)? ☐ No ☐ Yes, which and who has them? _____	

The child and the family's health habits

My child's sleep pattern suits our family's everyday life ☐ Yes ☐ No	My child usually sleeps the entire night without waking up ☐ Yes ☐ No
My child usually falls asleep easily ☐ Yes ☐ No	Does your child take naps? ☐ Yes ☐ No
Does anything related to how your child sleeps make your family's everyday life harder? ☐ No ☐ Yes, please specify _____	
How many hours does your child spend outdoors every day?	
Special observations on your child's physical activity and outdoor activities	
Our family engages in physical activity ☐ daily ☐ a few times per week	☐ less often than weekly ☐ never

Child's meals and diet

National nutrition recommendations

My child generally eats ☐ breakfast ☐ lunch ☐ afternoon snack	☐ dinner ☐ evening snack
Does your child have snacks every day? ☐ No ☐ Yes, what do they snack on? _____	
Your child's diet includes ☐ milk and/or dairy products ☐ vegetables, fruit and berries	☐ meat ☐ fish
Does your child get a vitamin D supplement ☐ daily ☐ sometimes	☐ never
If you wish, you can tell us more about their diet and eating habits.	

Family diet

Our family's diet is

☐ omnivorous diet ☐ vegetarian diet

☐ other diet _____

Does your family eat together?

What is good about your family's eating habits?

What about your family's eating habits should be improved?

Child's oral health

My child's teeth are brushed

☐ twice a day or more often ☐ less than once a day

☐ once a day ☐ never

Do you brush your child's teeth with fluoride toothpaste?

☐ Yes ☐ No

Does your child use xylitol products?

☐ Yes ☐ No

Has your child had an oral health examination in the past year?

☐ Yes ☐ No

Media usage

The Small children and screen time recommendation (in Finnish)

Om ditt barn dagligen tillbringar tid framför en skärm (smarttelefon, dator, spelkonsoler, TV osv.), i vilka situationer sker detta?

☐ while eating ☐ as a reward for something

☐ when calming down ☐ other, please specify

_____

If your child spends time looking at a screen every day, how much time per day (please estimate)?

Tobacco and substance use by adults in the family

Substance screening form for maternity and child health clinics

Use of nicotine products: summary of what, how many per day?

Alcohol: AUDIT score (both/all parents)

Drugs and medicines: summary what, how much?

Is your child exposed to tobacco smoke?

☐ daily ☐ sometimes ☐ never

Information on the family's wellbeing

Does your family spend enough time together?

☐ Yes ☐ No

How does your family spend time together?

Our family

☐ tends to give encouragement and positive feedback
☐ shares household chores
☐ makes everyone feel safe, and usually the atmosphere is peaceful
☐ puts feeling into words
☐ reconciles conflicts
☐ tends to share what has happened during the day
☐ has agreed on rules together

Do you feel that you need help in matters related to the upbringing of your child or everyday life in the family?

☐ yes, what kind of help? _____
☐ no
☐ we already receive help, from whom and what kind of help? _____
☐ we have received help in the past, from whom and what kind of help? _____

Family concerns or issues taking up resources that affect your child's wellbeing

Our family faces the following

☐ long-term illnesses (physical/mental)
☐ difficulty coping, exhaustion or depression
☐ insecurity or violence
☐ substance abuse problems or addiction
☐ financial worries
☐ grief or loss
☐ other topical issues
☐ none of the above

If you wish, you may tell us more

Who can provide support for your family's everyday life if necessary?

☐ grandparents
☐ former spouse
☐ neighbours
☐ friends
☐ others
☐ no one

If you wish, you may tell us more

What about your child delights you?

What are your family's strengths?

Do you have any wishes for the health examination?

The following persons have participated in filling in the form