2.5 Years Questionnaire

History

Do you have any concerns about your child?

Yes No

Does your child have any special health care needs?

Yes No

Has your child seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

Has your child had any procedures or tests done since their last visit?

Yes No

Household

How many people are living in this child's home? _______________

If this child is not living with both biological parents, what is living situation? ______________________

Social History

Have there been any major changes for your child or in your family lately?

Yes No

Who takes care of your child during the day? _________________________

*What are your plans for childcare over the next year?*_______________________

Does your child live with anyone who smokes or spend time in any places where people smoke?

Yes No

Does anyone smoke in the car your child travels in?

Yes No

Nutrition

How many servings of dairy products does your child have per day? For example, yogurt and cheese.

Less than 2 2-3 More than 3

How many servings of vegetables does your child have per day?

Less than 2 2-3 More than 3

How many servings of fruits does your child have per day?

Less than 2 2-3 More than 3

How many servings of whole grains does your child have per day?

Less than 4 4-6 More than 6

How many servings of protein does your child have per day? For example, meat, eggs, beans, tofu, etc.

Less than 2 2-4 More than 4

How many servings of junk food does your child have per day? For example, chips, candy, cookies, cakes, etc.

____

How often does your child have a fast food meal?

1 per day 4-6 a week 1-3 a week 1-3 a month 6-11 a year 1-5 a year never

*How many ounces (oz) of milk does your child drink per day?*_________ *oz*

*How many ounces (oz) of juice does your child drink per day?*_____________*oz*

How many ounces (oz) of soda or drink mixes like Kool-Aid does your child drink per day?_________ oz

Does your child take vitamins or supplements?
Yes No
Does your child watch TV while eating?
Yes No
Does your child have any problems with eating?
Yes No

Elimination

Does your child have any problems with urinating or going pee?
Yes No
Does your child have any problems with bowel movements or going poop?
Yes No
Is your child toilet trained?
During the day and most nights
During the day but not at night yet
Not yet
In progress

Sleep

How many hours does your child sleep per day?_________ hours
Does your child have problems with sleeping?
Yes No

Oral Health

How often are your child's teeth brushed?
Once a day
Twice a day
Does not brush teeth
How often does your child floss teeth?
Once a day Twice a day Does not floss teeth
How often does your child see the dentist?
Once a year Twice a year Does not see dentist regulary
Is your child drinking water that is fluoridated?
Yes No
Has your child had fluoride varnish applied to their teeth in the last 6 months?
Yes No Not previously recommended
Does your child continually drink from a bottle or sippy cup throughout the day?
Yes No
Does your child snack frequently?
Yes No
Have you, the parent or primary caregiver, had any cavities in the last 12 months?
Yes No
Is your child eligible for Medicaid?
Yes No

Physical Activity

How many hours a day does your child spend being physically active? _____________
Is your family physically active together?
Yes No
How many hours a day does your child spend watching TV or other electronic device screen?

For example, computer, tablet, game console?
Never Less than 2 hours More than 3 hours

Development

Do you read or play rhyming games with your child?
Yes No
When reading together, do you ask your child questions about the pictures or stories?
Yes No
Do you take your child to parks, museums, libraries or participate in other educational activities outside the home?
Yes No

Behavior

Does your child play with other children like in playgroups or childcare?
Yes No
Does your child have a best friend or group of friends?
Yes No
Is your child cooperative?
Yes No
Do you provide your child with choices?
Yes No
Are all caregivers giving the same amount of patience, setting the same limits and doing the same discipline?
Yes No
What type of discipline do you use? ____
Does your child have trouble with hitting or biting?
Yes No

Safety

When your child rides in a car, do you use a car seat?
Every time Occasionally Never
Where, in the car, is the car seat located?
Front seat Back Seat
Which way is the car seat facing?
Forward Rear

Are there working smoke detectors in the house?
Yes No
Are there working carbon monoxide detectors in the house?
Yes No
Do you have a fire escape plan?
Yes No
Do you have a list of emergency numbers that are easy to find?
Yes No
Do you feel safe in your home?
Yes No
Do you feel safe in your community?
Yes No
Do you know how or where to get help if you don't feel safe in your home?
Yes
No

In places where this child spends time, are medications, chemicals and insecticides kept locked up?

Yes No

Is the phone number for Poison Control easily located?

Yes No

Is your child left alone on high places like changing tables or countertops?

Yes No

Do you keep furniture away from windows?

Yes No

Is your child able to climb out of their crib?

Yes No

Are your stairs gated at the top and bottom?

Yes No

Do you watch your child when they play outside?

Yes No

When playing outside, does your child stay within fences and gates?

Yes No

Do you watch your child closely when playing near streets or driveways?

Yes No

Do you keep your child away from moving machines, lawn mowers, streets and driveways?

Yes No

Are the cords to window blinds out of your child's reach?

Yes No

Do you stay within arms reach of your child when near water like bath tub and swimming pools?

Yes No

Is there a swimming pool, pond, or lake near your home or where your child spends time?

Yes No

Is the temperature of your hot water at or below 120?F in the places your child frequents? (For example, at home, at babysitter's or daycare)

Yes No Unknown

Are there barriers around space heaters, woodstoves or kerosene heaters?

Yes No

Are cigarettes, lighters, matches and alcohol out of your child's sight and reach?

Yes No

Does your child wear sunscreen or sun protective clothing when outside?

Yes No

Does your child wear a helmet when riding a tricycle, bicycle, scooter, skateboard, skis or snowboard?

Yes No

Have you taught your child how to safely approach pets?

Yes No

Are there any guns in your home or where your child spends time?

Yes No Unknown

Are you comfortable answering your child's questions about their body?

Yes No

Does your child know it is never ok for an older child or adult to ask to see their private parts?

Yes No

Doe/can your Child:

Have communicates needs

Yes No

Name 1 picture

Yes

No

point to 6 body parts

Yes No

speech half understandable

Yes No

understand 2 step command

Yes No

imitate vertical line

Yes No

tower of 6 blocks

Yes No

tower of 8 blocks

Yes No

jump up

Yes No

turns a door knob

Yes No

put on clothing

Yes No

wash and dry hands

Yes No