



Well Child Check: 2 year visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since
your last appointment in the office?

No Yes

Has your child had any reactions to vaccinations in the past?

No Yes

Development:

Can your child kick a ball?

Yes No

Can your child jump in place (jump with both feet off the ground)?

Yes No

Does your child say more than 50 words?

Yes No

Does your child use pronouns (I, me, you)?

Yes No

Does your child understand directions?

Yes No

Does your child imitate housework?

Yes No

Can your child run, climb and walk up and down stairs?

Yes No

Does your child know 6 or more body parts?

Yes No

Is your child showing interest in potty training?

Yes No

Do you and your child read together daily?

Yes No

Do you have concerns about how your child hears or speaks?

No Yes

Do you have any concerns about how your child sees?

No Yes

Does your child hold objects close when trying to focus?

No Yes

Do your child's eyes appear unusual or seem to cross, drift or be lazy?

No Yes

Do your child's eyelids droop or does one eyelid tend to close?

No Yes

Dental Health:

Do you help your child brush and floss his/her teeth daily?

Yes No

Does your child's primary water source contain fluoride?

Yes No Unsure

If no, does your child take a fluoride supplement?

Yes No N/A

Does your child have a dentist?

Yes No

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV, play video games, or use
a smart phone or tablet?

No Yes

Does your home have a working smoke detector?

Yes No

Have you turned your water temperature down to low-warm
(less than 120 degrees)?

Yes No N/A

If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	N/A
Does your home have cleaning supplies/medicines/matches locked away?	Yes	No	
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Do you always stay with your child when she/he is in the bathtub?	Yes	No	
Do you and your child spend time near water (pool, river or lake)?	No	Yes	
If so, is your child always safely supervised?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Do you always place your child in a car seat in the back seat?	Yes	No	
Is your car seat the right one for the age and size of your child?	Yes	No	
Do you always check for children before backing your car out?	Yes	No	
Does your child spend time in a home where a gun is kept?	No	Yes	Skip
If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your child wear a helmet when riding a tricycle or anything with wheels?	Yes	No	N/A
Does your child spend time with anyone who smokes?	No	Yes	

Risk Assessment for Lead Exposure:

Does your child participate in any publicly supported programs (Medi-Cal, CHDP, Healthy Families, WIC)?	No	Yes
Does your child live in or regularly visit a house or child care facility built before 1950?	No	Yes
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?	No	Yes
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes
Does your child take any imported remedies or supplements?	No	Yes

Tuberculosis Screening:

- Was your child born in a country with an elevated TB rate?
This includes all countries **other than** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.
- No Yes
- Has your child visited or lived in a country with an elevated TB rate
for one month or more? (Countries other than those listed above)
- No Yes
- Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection?
- No Yes Unsure
- Is your child immunosuppressed (currently or planned)?
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.
- No Yes

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):

- Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (heart attack, stroke, angioplasty, angina or bypass surgery)?
- No Yes
- If yes, who? _____ at what age? _____
- Do either of the child's parents have a cholesterol of 240 or higher?
- No Yes
- If yes, who? _____ at what age? _____

Sleep:

- How many hours does your child sleep at night? _____ hours
- How many hours does your child nap throughout the day? _____ hours

Nutrition/Physical Activity:

- Does your child drink? (circle all appropriate): [breast milk] [whole milk] [other type of milk _____]
- How many ounces of milk does your child drink per day? _____ oz
- How much juice does your child drink in 24 hours? _____ oz
- Does your child drink from a bottle or take a pacifier?
- No Yes
- Is your child eating fruits and vegetables at least two times per day?
- Yes No
- Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu?
- Yes No
- Does your child eat junk foods such as chips, fries, ice cream or fast food more than twice per week?
- No Yes
- Does your child drink soda, sports drinks, energy drinks or other sweetened drinks?
- No Yes

Patient Name

Date of Birth

Does your child eat iron rich foods (such as meat, eggs,
iron-fortified cereals or beans)?

Yes No

Do you have trouble affording to buy food for your family?

No Yes

Does your child play actively most days of the week?

Yes No

Do you have any concerns about your child's weight or feeding?

No Yes

Elimination:

Does your child have bowel movements on a regular basis with
a normal (soft) consistency?

Yes No

Please list any medications or supplements your child is taking:

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues:

Please list any known allergies to medicines:

Please list any known food allergies:

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	☐ Patient Declined the SHA
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
PCP's Signature		Print Name:			Date:



M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs)	Yes	No
5. Does your child make <u>unusual</u> finger movements near his or her eyes? (FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE , pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE , does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE , if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE , being swung or bounced on your knee)	Yes	No

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Child's Name: _____ DOB: _____

Completed by: _____ Date completed: _____