

General

1. List any concerns you want to discuss today:

2. Does your child have screen time (smartphone, tablet, TV) more than 1 hour daily?	No	Yes
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3. Does your child have access to screens in their bedroom?	No	Yes
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4. Does your child play actively for at least one hour per day?	Yes	No
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5. Does your child sleep through the night?	Yes	No
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6. Does your child snore more than a little?	No	Yes
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Nutrition

7. How many cups of milk is your child drinking per day?

8. Is your child eating 5 servings of fruits and vegetables daily?	Yes	No
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9. Does your child eat junk food more than 2-3 times a week? (Examples: candy, chips, cookies, sweet cereal, fast food.)	No	Yes
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10. Does your child drink juice or other sweetened drinks more than 1-2 times per week?	No	Yes
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11. Does your child still drink from a bottle?	No	Yes
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12. Does your child have any problems with bowel movements (poop)?	No	Yes
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Oral health

13. Does your child see a dentist at least 2 times a year? (If so, skip to the next section.)	Yes	No
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If not...

a. Has any caregiver had cavities/dental decay in the past year?	No	Yes
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b. Does your child drink something other than water from a cup continually and/or snack frequently throughout the day?	No	Yes
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c. Does your water contain fluoride or is your child on a fluoride supplement?	Yes	No	Not sure
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d. Do you brush your child's teeth with a fluoride-containing toothpaste (size of a grain of rice) twice daily?	Yes	No
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Lead

- | | | |
|---|----|-----|
| 14. Is your child regularly in a house built before 1978? | No | Yes |
| 15. Does your child have a brother, sister or playmate who ever had lead poisoning? | No | Yes |

Tuberculosis

- | | | | |
|--|----|-----|----------|
| 16. Is your child at risk for infection with tuberculosis? (Includes children born in Africa, Asia, Latin America, or eastern Europe; children who have stayed with family in one of those places for more than a week, or if exposed to anyone with active TB.) | No | Yes | Not sure |
|--|----|-----|----------|

Safety checklist*Check all that apply.***True****I have questions**

- | | True | I have questions |
|--|--------------------------|--------------------------|
| 17. My child rides in a 5-point harness car seat. | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. My child wears a helmet when on a tricycle or bicycle. | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. The crib mattress is at the lowest position. | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. We apply sunscreen if out in the sun for longer than 15-30 minutes. | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. There is a fence with a secure gate preventing our child from accessing the pool/lake/river near our home (or there is no pool, lake or river nearby). | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Our gun is locked up, with the ammunition separate (or we don't have a gun). | <input type="checkbox"/> | <input type="checkbox"/> |

SWYC

Survey of Well-Being in Young Children

30 month valid 23m 0d – 28m 31d**Developmental milestones**

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. Please be sure to answer all the questions.

Adapted from SWYC, 30 months

- | | Not yet | Somewhat | Very much |
|---|--------------------------|--------------------------|--------------------------|
| 23. <i>Names at least one color</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. <i>Tries to get you to watch by saying "Look at me"</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

		Not yet	Somewhat	Very much
25.	<i>Says his or her first name when asked</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	<i>Draws lines</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	<i>Talks so other people can understand him or her most of the time</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	<i>Washes and dries hands without help (even if you turn on the water)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	<i>Asks questions beginning with "why" or "how" — like "Why no cookie?"</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	<i>Explains the reasons for things, like needing a sweater when it's cold</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	<i>Compares things — using words like "bigger" or "shorter"</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32.	<i>Answers questions like "What do you do when you are cold?" or "...when you are sleepy?"</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PPSC — Preschool Pediatric Symptom Checklist

Not at all

Somewhat

Very much

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

Does your child...	33. Seem nervous or afraid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	34. Seem sad or unhappy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	35. Get upset if things are not done a certain way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	36. Have a hard time with change?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	37. Have trouble playing with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	38. Break things on purpose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	39. Fight with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	40. Have trouble paying attention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child...	41. Have a hard time calming down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	42. Have trouble staying with one activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	43. Aggressive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	44. Fidgety or unable to sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is it hard to...	45. Angry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	46. Take your child out in public?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	47. Comfort your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	48. Know what your child needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	49. Keep your child on a schedule or routine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	50. Get your child to obey you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

POSI — Parent's Observations of Social Interactions	Many times a day	A few times daily	A few times a week	Less than once a week	Never
51. Does your child bring things to you to show them to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always	Usually	Sometimes	Rarely	Never
52. Is your child interested in playing with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. When you say a word or wave your hand, will your child try to copy you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Does your child look at you when you call his or her name?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Does your child look if you point to something across the room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. How does your child <i>usually</i> show you something he or she wants? (Circle all that apply.)	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
57. What are your child's favorite play activities? (Circle all that apply.)	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round, like fans or wheels

Parent concerns	Not at all	Somewhat	Very much
58. Do you have concerns about your child's learning or development?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Do you have any concerns about your child's behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family questions	No	Yes
<i>Because family members can have a big impact on your child's development, please answer a few questions about your family below:</i>		
60. Does anyone who lives with your child smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
61. In the last year, have you ever drunk alcohol or used drugs more than you meant to?	<input type="checkbox"/>	<input type="checkbox"/>

62. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	<input type="checkbox"/>	<input type="checkbox"/>						
63. Has a family member's drinking or drug use ever had a bad effect on your child?	<input type="checkbox"/>	<input type="checkbox"/>						
		Never true	Sometimes true	Often true				
64. Within the past 12 months, we worried whether our food would run out before we got money to buy more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Over the past two weeks, how often have you been bothered by any of the following problems?</i>		Not at all	Several days	More than half the days	Nearly every day			
65. Having little interested or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
66. Feeling down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		No tension	Some tension	A lot of tension	Not applicable			
67. In general, how would you describe your relationship with your spouse/partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		No difficulty	Some difficulty	Great difficulty	Not applicable			
68. Do you and your partner work out arguments with:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
69. During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7