12 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have concerns about your child's health?	NO	YES
2	Do you have any concerns about managing your child's behavior?	NO	YES
3	Has your child had any problems with shots or immunizations?	NO	YES
4	Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

5	Do you have any concerns about your child's hearing?	NO	YES
6	Do you have any concerns about your child's vision?	NO	YES
7	Does your child ever look cross-eyed?	NO	YES

Feeding/Nutrition

8	Is your child breastfeeding?	YES	NO
	a. How often?		
9	Is your child taking formula or milk well?	YES	NO
	a. Which kind of milk or formula?		
	b. How much milk per day?		
10	Is your child eating three meals of solid food per day?	YES	NO
11	Does your child snack more than 2 times a day?	NO	YES
12	Is your child feeding him or herself?	YES	NO
13	Can your child drink from a sippy cup?	YES	NO
14	Are you weaning from the bottle?	YES	NO
15	Does your child drink juice or other sweetened drinks?	NO	YES
16	Do you give your child any vitamins or supplements?	YES	NO

Oral Health

17 Does your child fall asleep with a bottle and/or wake at night to breast or bottle feed?	NO	YES
18 Does your child only drink milk at meals?	YES	NO
19 Are you using a soft toothbrush or cloth to clean your child's teeth and gums 2 times per day?	YES	NO
20 Do you have a dentist for your child?	YES	NO
21 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

22 Does your child have any problems with bowel movements (pooping)?	NO	YES

Activity / Exercise / Screen Time

23 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
24 Do you play with and read to your child every day?	YES	NO
25 Does your child get supervised floor time every day?	YES	NO

Sleep

26 Does your child sleep through the night?	YES	NO
27 Do you have a bedtime routine?	YES	NO

Social Stressors

28 Do you feel you receive the support you need?	YES	NO	
29 Have there been any major changes or stresses in your family recently?	NO	YES	
30 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
31 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

Development

32	Does your child point when he/she wants something or is interested in something?	YES	NO
33	Does your child babble, copy words you say and make sounds?	YES	NO
34	Does your child say one or two words?	YES	NO
35	Can your child follow simple directions?	YES	NO
36	Does your child give you a book to read?	YES	NO
37	Does your child wave bye-bye and play peek-a-boo?	YES	NO
38	Does your child bang toys together?	YES	NO
39	Does your child cry when you leave?	YES	NO
40	Does your child eat finger foods with thumb and forefinger (pincer)?	YES	NO
41	Does your child walk well or with a little help? (like holding onto your fingers)	YES	NO
42	Can your child creep up stairs?	YES	NO

Lead

43	Is your child regularly in a house built before 1978?	NO	YES
	a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
44	Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

45 Do you always stay close enough to touch your child when he or she is in the bath?	YES	NO	
46 Do you keep furniture away from windows or use window guards?	YES	NO	
47 Does your child wear any jewelry (including necklaces)?	NO	YES	
48 Do you have a gate on your stairs?	YES	NO	
49 Is the crib mattress at the lowest position?	YES	NO	
50 Do you hold or carry hot liquids around your child?	NO	YES	
51 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO	
52 Does anyone smoke or vape around your child?	NO	YES	
53 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
54 Are you using a shade or sunscreen if your child is in the sun more than 15-30 minutes?	YES	NO	
55 Do you keep plastic bags and latex balloons away from your child?	YES	NO	
56 Is your water heater turned to below 120 degrees?	YES	NO	
57 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO	
58 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
59 Do you have the number for Poison Control?	YES	NO	
60 If there is a swimming pool, pond, or lake near your home, is it secured so that your child cannot access it?	YES	NO	N/A
61 If there is a gun in the home, is it locked in a safe with ammunition stored separately?	YES	NO	N/A

Tuberculosis

62 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
63 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
64 Was your child born in a high-rick country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
65 Has your child traveled to a high-risk country for more than a week?	NO	YES