2 Year 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	Has your child had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

6	Is your child drinking milk?	YES	NO
	a. What kind of milk?		
	b. How many ounces of milk per day?		
7	Is your child eating 5 servings of fruits and vegetables daily?	YES	NO
8	When your child eats grains (cereal, bread, pasta, crackers, waffles, rice, etc), are they mostly whole grains?	YES	NO
9	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than 2-3 days per week?	NO	YES
10	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
11	Is your child drinking from a bottle?	NO	YES
12	Does your child drink juice or other sweetened drinks?	NO	YES
13	Do you give your child any vitamins or supplements?	NO	YES
14	Are you worried about your child's weight?	NO	YES

Lipids

15	Does your child have a parent who has had a stroke or heart attack before age 55?	NO	YES
16	Does your child have a parent or sibling with high cholesterol?	NO	YES

Oral Health

17	Does your child see a dentist at least 2 times a year? **(If your answer is yes, please skip ahead to #22)**	YES	NO	
	ANSWER #18-21 *ONLY* IF YOUR CHILD DOES *NOT* SEE A DENTIST			
18	Has any caregiver had cavities/dental decay in the past year?	NO	YES	
19	Does your child drink something other than water from a cup continually and/or snack frequently throughout the day?	NO	YES	
20	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO	NOT SURE
21	Do your brush your child's teeth with a fluoride-containing toothpaste (size of a grain of rice) twice daily?	YES	NO	

Elimination

22	Does your child have regular soft bowel movements (poop)?	YES	NO
23	Have you started toilet (potty) training?	YES	NO
24	Does your child tell you when a diaper needs to be changed?	YES	NO

Activity / Exercise / Screen Time

25	Does your child have screen time (smartphone, tablet, TV) more than 1 hour daily?	NO	YES
26	Does your child have bedroom access to screen time?	NO	YES
27	Do you read to your child every day?	YES	NO
28	Does your child play actively for at least 1 hour per day?	YES	NO

Sleep

29	Does your child sleep through the night?	YES	NO
30	Do you have a bedtime routine?	YES	NO
31	Does your child fall asleep on his own, in his/her own bed?	YES	NO
32	Does your child snore more than a little?	NO	YES

Social Stressors

33 Have there been any major changes or stresses in your family recently?	NO	YES	
34 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
35 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
36 Do you always feel safe in your home?	YES	NO	

Behavior

37 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
38 Do you praise your child when he/she is behaving well?	YES	NO

Development

(If you are completing the Ages and Stages questionnaire please skip this section)

39 Does your child have a fifty word vocabulary?	YES	NO
40 Does your child use 2-3 word phrases or sentences ("More milk" or "Hi Mom")	YES	NO
41 Does your child know 6 or more body parts?	YES	NO
42 Does your child copy things you do?	YES	NO
43 Does your child follow 2 step instructions?	YES	NO
44 Does your child walk up and down stairs while holding on?	YES	NO
45 Does your child turn pages one at a time?	YES	NO
46 Can your child name some pictures in books?	YES	NO
47 Can your child hold a cup with one hand?	YES	NO
48 Can your child jump with both feet on the floor?	YES	NO
49 Can your child throw a ball overhand?	YES	NO
50 Can your child kick a ball?	YES	NO
51 Does your child try to write with a pencil?	YES	NO

Lead

52 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
53 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

54	Is the crib mattress at the lowest position?	YES	NO	
55	Does anyone smoke or vape around your child?	NO	YES	
56	Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO	
57	Do you watch your child when he/she plays outside?	YES	NO	
58	Does your child wear a helmet when on a tricycle or bicycle?	YES	NO	
59	Is there a gun in the home?	NO	YES	
	a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY
60	Does your child ride in a safety seat, in the back seat?	YES	NO	
61	Do you have the number for Poison Control? (1-800-222-1222)	YES	NO	
62	If your child has fair skin, do apply sunscreen if out in the sun for longer than 15 to 30 minutes?	YES	NO	DOESN'T APPLY
63	Is there a swimming pool, pond or lake near your home?	NO	YES	
	a. If yes, it is secured so that your child cannot access it?	YES	NO	DOESN'T APPLY

Tuberculosis

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