Patient Name:

Date of Birth:

Well Child Check: 2 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No ☐ Yes ☐
Has your child had any reactions to vaccinations in the past? No ☐ Yes ☐

Development: Can your child (check all that apply) –

☐ kick a ball? ☐ jump in place? ☐ walk up/down stairs? ☐ run? ☐ climb?
☐ use more than 50 words? ☐ use pronouns (I, me, you)? ☐ know 6 or more body parts?
☐ understand directions? ☐ scribble? ☐ use utensils?

Is your child showing interest in potty training? Yes ☐ No ☐
Do you and your child read together daily? Yes ☐ No ☐
Who provides daytime care for your child? _____

Nutrition/Elimination/Activity:

What type of milk does your child drink? _____ How much per day? _____ cups
How much yogurt per day? _____ How much cheese per day? _____
What dietary restrictions does your child have, if any?_____
Is your child eating 4 servings per day of a variety of fruits and vegetables? Yes ☐ No ☐
Does your child eat iron-rich foods (meat, iron-fortified cereal, or beans)? Yes ☐ No ☐
How much juice or sweet beverages does your child drink? _____ oz
Does your child eat junk/fast food more than twice per week? No ☐ Yes ☐
Are there any problems with pooping or peeing? No ☐ Yes ☐
Does your child play actively most days of the week? Yes ☐ No ☐
Your child's medications/vitamins/supplements: _____

Dental Health:

Does your child see a dentist every 6 months? Yes ☐ No ☐
Does your child (with your help) brush his/her teeth daily? Yes ☐ No ☐
Does your child use a pacifier? No ☐ Yes ☐
Does your child drink from a bottle? No ☐ Yes ☐

Sleep:

How long does your child sleep at night? ____ hours
How long does your child nap? ____ hours

Staying Healthy/Safety:

Does your child get any screen time? No ☐ Yes ☐
Does your home have a working smoke detector? Yes ☐ No ☐
Is your water temperature set to less than 120 degrees? Yes ☐ No ☐ N/A ☐
Is your child always supervised when near water, including the bathtub? Yes ☐ No ☐

Do you have safety guards on upper floor windows and gates for the stairs?	Yes ☐	No ☐	N/A ☐
Does your home have cleaning supplies/medicines/matches locked away?	Yes ☐	No ☐	
Is the Poison Control Center number (800-222-1222) posted by/in your phone?	Yes ☐	No ☐	
Does your child use sun protection when outdoors?	Yes ☐	No ☐	
Is your car seat appropriately sized and in the back seat?	Yes ☐	No ☐	
Do you always check for children before backing your car out?	Yes ☐	No ☐	
Does your child wear a helmet and sit in an approved bike seat when on a bike?	Yes ☐	No ☐	N/A ☐
Are all guns stored in a gun safe or locked with ammunition separate from gun?	Yes ☐	No ☐	N/A ☐
Does your baby spend time with anyone who smokes or vapes?	No ☐	Yes ☐	

Please list any new major family medical issues:

_____

Who lives in the home with your child?

_____

What international travel has your child had since their last well check? (where and how long)

_____

What plans are there for international travel with your child in the next 12 months? (where and how long)

_____

What concerns would you like to discuss today?

_____

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L15682

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 unusual 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 ☐

Child's Name: _____ DOB: _____

Completed by: _____ Date completed: _____