Appt Date_____ 12 month Check Up

Patient Name_____DOB_____

Name of person filling out form _____ Phone number_____

Nutrition:

What does your child drink? (circle all that apply) Formula Breast Milk Whole Milk Soy Milk

How many ounces of milk does your child drink per day? _____

How many ounces of juice does your child drink per day?_____

How many ounces of water does your child drink per day?_____

Does your child eat a variety of meats, fruits, and vegetables each day?_____

Bowel/Bladder:

Any concerns about your child's voiding or stooling?_____

Sleep:

How many hours does your child sleep at night? _____

How many naps does your child take during the day? _____ How long are the naps? _____

Hearing/ Vision:

Any concerns about your child's hearing or vision?_____

Social hx:

Does your child attend daycare, preschool, or stay at home?_____

How much screen time does your child get each day? _____

Development: Please check the following developmental milestones your child has accomplished:

___Cruises
___Stands alone
___Walks with support
___Walks alone
___Has occasional "tantrums"
___Uses pincer grasp to pick up small objects
___Specifically says "mama", "dada" to his/her mother and father
___Says one to four other words
___Plays with adult-like objects (telephone, brush, etc.)
___Imitates

Advice and Guidance for Parents: *(please check off as you read)*

___Accidents are the main cause of injury; watch out for: falls, cords and outlets, choking hazards

___Fluoride supplement is needed unless you have city water or drink fluorinated bottled water

___Wear SPF 30 or greater for sun exposure

___"Catch" your child being good

___Read to your child at least once a day

___Smoke Exposure: Minimize your child's exposure to cigarette smoke

___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____

___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___

___You should brush your child's teeth every night, twice a day if possible (this is "non-negotiable")

___Change to whole milk in a sippy cup (a child needs only 12-16 oz. of whole milk per day)

___ Sleep: Your child should have 14 hours of sleep per day (2 naps a day and sleep all night in own room)

___ Behavior: "distraction and removal" is the best solution for tantrums

(for podcasts on Sleep and Behavior, go to www.shotshurtless.com)

PEDS Response Form

_____
Provider

Child's Name _____ *Parent's Name* _____

Child's Birthday _____ *Child's Age* _____ *Today's Date* _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?
Circle one: No Yes A little COMMENTS:

Please list any other concerns.