Appt Date_____ 2 year 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 that you notice your child accomplishing:

___Takes some clothes off

___Builds a 4 to 6-block tower

___Jumps with two feet off the floor

___Throws and kicks a ball

___Goes up and down stairs without your help

___Plays alongside other children

___Uses a spoon and fork

___Says 20 or more words (20-200 is normal range)

___Says two- and three-word phrases

___Uses "I" and "me"

___50% of speech is understandable by a stranger

___Knows some body parts

How many words does your child say?_____

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

___Accidents are the main cause of injury, be careful around pools, things that cause burns, choking hazards

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

___Wear SPF 30 or greater for sun exposure

___Occasionally allow your child make his/her own choices, but limit to 2 acceptable options.

___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___

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

___Encourage potty training if your child shows interest. Many children will begin potty training at 2 ½

___ Nutrition: Change to skim milk and limit to 12 to 20 oz. daily.

___ Behavior: "Catch" your child being good. Put in timeout for two minutes for major offenses.

___ Sleep: Your child should have 13 hours of sleep per day (1 nap plus all night in own room)

(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.

www.m-chat.org

Child's name _____ Date _____

Age _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

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