

Name: _____ Date of birth: _____

Health Status Questionnaire – 2 Years

Child lives with: mother father both parents other: _____

Childcare: daycare babysitter stays at home other: _____

Feedings:

__ cup __ bottle(should be weaned) __ breast __ solid foods __ meals __ snacks
whole milk: <16oz/day 16-24oz/day 24-30oz/day >30oz/day
__picky eater __prefers milk __no water __lots of juice (should be < 4-6 oz per day)

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Car seat use:	Y	N	Smoke detectors:	Y	N
Sunscreen:	Y	N	Fire extinguishers:	Y	N
Insect protection:	Y	N	Firearms/guns in house:	Y	N
Home child proofed:	Y	N	Locked away:	Y	N
Dental visit:	Y	N	Passive smoke exposure:	Y	N

Lead Exposure Questions:

Does your child live in or regularly visit a house or child care facility built before 1950? Y N

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or recently has been renovated or remodeled? Y N

Does your child have a sibling or playmate who has or had lead poisoning? Y N

Tuberculosis (Tb) Screen Questions:

Has your child ever received BCG (Tb vaccine given in some foreign countries)? Y N

Has there ever been tuberculosis/Tb in any household member? Y N

Was your child born or traveled for longer than 2 weeks to a country at high risk for Tb (countries other than Canada, Australia, New Zealand or western Europe)? Y N

Development concerns: none speech motor social cognitive vision hearing

Do you have any concerns about your child?

(continue on back)

Does your child:		
Stack 5 or 6 blocks/objects?	Y	N
Kick a ball?	Y	N
Walk up steps?	Y	N
Point to at least 2 pictures that you name from a book?	Y	N
Combine 2 words?	Y	N
Throw ball overhand?	Y	N
Name pictures (cat, dog, bird, etc)?	Y	N
Jump?	Y	N
Follow 2 part command?	Y	N
Turn pages of book?	Y	N
Say 20-50 words?	Y	N

M-CHAT-R (autism screen):

- If you point at something across the room, does your child look at it?
(if you point at a toy, does your child look at the toy?) Y N
- Have you ever wondered if your child might be deaf? Y N
- Does your child play pretend or make-believe? (pretend to drink from cup,
talk on phone or feed a doll or stuffed animal?) Y N
- like climbing on things like furniture, playground equipment or stairs? Y N
- Does your child make unusual finger movements near his/her eyes?
(wiggle his/her fingers close to his/her eyes?) Y N
- Does your child point with one finger to ask for something or to get help?
(pointing to a snack or toy that is out of reach) Y N
- Does your child point with one finger to show you something interesting?
(pointing to airplane in the sky or big truck in the road) Y N
- interested in other children?(watch other children, smile at them or go to them) Y N
- show you things by bringing them to you or holding them up for you
to see-not to get help, but just to share?(showing you flower or toy) Y N
- Does your child respond when you call his or her name?
(look up, talk or babble, or stop what he/she is doing when called) Y N
- When you smile at your child, does he/she smile back at you? Y N
- get upset by everyday noises? (scream/cry to vacuum cleaner/loud music) Y N
- Does your child walk? Y N
- look you in the eye when you are talking to, playing with or dressing him/her? Y N
- copy what you do?(like wave bye-bye, clap or make funny noise) Y N
- If you turn your head to look at something, does your child look
around to see what you are looking at? Y N
- Does your child try to get you to watch him/her?
(look at you for praise, or say “look” or “watch me”) Y N
- understand when you tell him/her to do something? (if you don’t point,
can he/she understand “put the book on the chair”/ “bring me the blanket”) Y N
- If something new happens, does he/she look at your face to see how you feel
about it?(if hears a strange/funny noise, or see new toy, look at your face) Y N
- like movement activities? (being swung or bounced on your knee) Y N