

2.5 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 <u>ONLY</u> IF YOUR CHILD DOES <u>NOT</u> 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 you 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/her 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

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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

39 Does your child put 3-4 words together in a sentence?	YES	NO
40 Can other people understand what your child is saying at least half the time?	YES	NO
41 Does your child know the names of 8 or more body parts?	YES	NO
42 Can your child match animal sounds to the right animal?	YES	NO
43 Can your child brush teeth with help?	YES	NO
44 Does your child follow 2 step instructions?	YES	NO
45 Can your child jump with both feet off the floor?	YES	NO

Safety

46 Is the crib mattress at the lowest position?	YES	NO	
47 Does anyone smoke or vape around your child?	NO	YES	
48 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO	
49 Do you watch your child when he/she plays outside?	YES	NO	
50 Does your child wear a helmet when on a tricycle or bicycle?	YES	NO	
51 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
52 Does your child ride in a safety seat, in the back seat?	YES	NO	
53 Do you have the number for Poison Control?	YES	NO	
54 Do you put sunscreen on your child when in the sun for more than 15-30 minutes?	YES	NO	
55 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