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2 YEAR OLD PARENT SURVEY

Patients Name: _____ Date: _____

DEVELOPMENT

Does your child:

Have a vocabulary of more than 20 words?	N	Y
Combine 2 word phrases (ie: "mama up")?	N	Y
Scribble or color?	N	Y
Eat with a fork or spoon?	N	Y
Jump?	N	Y
Engage in pretend play?	N	Y
Have a high needs temperament?	Y	N

Do your other children have high needs temperaments? Y N

Do you read to your child for 20 minutes a day? N Y

Is your child shy? Y N

Do you have concerns about your child's relationship with his/her siblings? N/A Y N

DIET

Do you have concerns about your child's diet? Y N

Are you worried about your child's BMI? Yes Somewhat No

What kind of milk does your child drink? skim 1% 2% whole
How many ounces each day?

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

Does your child:

Eat 5 (or more) servings of fruits/vegetables daily?	N	Y
Have carbohydrates as the main part of his/her diet?	Y	N
Eat foods with whole grains and fiber?	N	Y
Eat 3 (or more) servings of dairy daily?	N	Y
Drink sugared soda, juice, or sports drinks regularly?	Y	N
Eat breakfast daily?	N	Y
Eat more than 2 snacks a day?	Y	N
Eat "fast food" one or more times weekly?	Y	N
Eat meals together as a family ("family meals")?	N	Y
Eat after dinner or before bedtime? (ie: dessert)?	Y	N
Get physical activity on a daily basis?	N	Y

Would you like some literature on diet for children? Y N

ELIMINATION

Do you have concerns about your child's toileting habits? Y N

How many stools does your child have per day? _____

Does your child routinely have hard stools or diarrhea? Y N

SLEEP

Do you have concerns about your child's sleep? Y N

Where does your child sleep? Everywhere parent's bed own bed crib

Does your child sleep through the night? N Y

Does your child still nap? N sometimes Y

Does your child snore? Y N

HEALTH OF FAMILY

Who lives with your child? _____

Are there any significant marital, health, financial or employment stresses at home? Y N
If yes, please explain (if you would like) _____

Are you: married partnered separated divorced single widowed other

Do you or your partner have depression or anxiety? Y N

Has there been any change in employment status (new job or lost job) for you or your partner in the last year? Y N

Do you have enough support with childcare? N Y

Do you have help with childcare? relative home daycare babysitter daycare center mother's helper

Are you involved with playgroups? N Y

Does anyone in your household use tobacco? Y N
If yes, would you like information on quitting? Y N

Does anyone in your house have issues with alcohol/drugs? Y N

Do you feel safe in your own home? N Y

DENTAL HEALTH

Does your child see a dentist every 6 months? N Y

Do you brush your child's teeth at least twice a day? N Y

Do you floss your child's teeth at least once a day? N Y

Is there fluoride in the water that your child drinks at home? Don't know N Y

Does your child still use a bottle or binky? Y N

SAFETY

How much "screen time" does your child have? _____

Has your child has any injuries this past year? Y N

Is your child in a car seat? N Y

Does your child always wear a helmet when riding a bike or tricycle? N Y

Do you have a trampoline? Y N

Is there a swimming pool at or near your home? Y N

Is there a gun in your home? Y N

HEALTH CARE MAINTENANCE

Has your child travelled outside the country this year? Y N

Has your child been hospitalized or had surgery this year? Y N

Has your child been to an ER or specialist this year? Y N

Do you have any questions about your child for today's visit?

_____

If you smoke and want to quit: 1-800-TRY-TO-STOP
If you feel you have an alcohol problem contact Alcoholics Anonymous: 1-800-443-9484
National Suicide Prevention Hotline number: 1-800-273-8255
Remember to check smoke detector/carbon monoxide detector batteries every 6 months. [6/17]

PLEASE TURN OVER AND COMPLETE BOTH SIDES!!

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