Child's Name: ________________________________ Date: ________________

3 YEAR OLD PARENT SURVEY

DEVELOPMENT

Does your child:

Speak in sentences?	N	Y
Know his/her colors?	N	Y
Recognize any letters?	N	Y
Put on some of his/her clothes?	N	Y
Ride a tricycle?	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 your read to your child for 20 minutes 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? No Somewhat Yes

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 /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

Is your child potty trained? N sort of Y

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? parent's bed child's bed crib

Does your child sleep through the night? N Y

Does your child nap or have a quiet time? N 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 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 day care babysitter day care 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

SAFETY

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

Has your child had 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?

1. ____

2. ____

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.