2½ 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 any 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 (acupuncturist, herbalist, naturopath)?	NO	YES

Feeding/Nutrition

4	Is your child drinking milk?	YES	NO
	a What kind of milk?		
5	Does your child eat fruits or vegetables at every meal?	YES	NO
6	Do you feed your child mostly whole grains?	YES	NO
7	Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods?	NO	YES
8	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
9	Is your child drinking from a bottle?	NO	YES
10	Does your child drink juice or other sweetened drinks?	NO	YES
11	Do you give your child any vitamins or supplements?	NO	YES
12	Are you worried about your child's weight?	NO	YES

Lipids

13 Does your child have parents or grandparents who had a stroke or heart attack before age 55?	NO	YES
14 Does your child have a parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

15 Are cavities a problem for you or anyone in your family?	NO	YES
16 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
17 Do you have a dentist for your child?	YES	NO
18 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

19 Does your child have regular soft bowel movements (poop)?	YES	NO
20 Have you started toilet (potty) training?	YES	NO

Activity/Exercise/Screen time

21 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
22 Does your child have any screen time in his/her bedroom?	NO	YES
23 Do you read to your child every day?	YES	NO
24 Do you do family activities like walking, bicycling, swimming, or dancing?	YES	NO
25 Do you do educational activities as a family, like go to libraries, museums, zoos, or on nature walks?	YES	NO

Sleep

26 Does your child sleep through the night?	YES	NO
27 Do you have a bedtime routine?	YES	NO
28 Does your child fall asleep on his/her own, in his/her own bed?	YES	NO
29 Does your child snore more than a little?	NO	YES

Social Stressors

30 Do you feel that you receive the support you need?	YES	NO	
31 Have there been any major changes or stresses in your family recently?	NO	YES	
32 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
33 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
34 Do you have any worries or concerns about daycare ?	NO	YES	

Behavior

35 Does your child have a lot of tantrums?	NO	YES
36 Do you have any questions about how to discipline your child?	NO	YES
37 Do you praise your child when he/she is behaving well?	YES	NO
38 Do you give your child choices?	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 Do you watch your child when he/she plays outside?	YES	NO
47 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO
48 Does your child wear a helmet when riding a scooter, tricycle, or bicycle?	YES	NO
49 Does anyone smoke or vape around your child	NO	YES
50 Is there a gun in the home?	NO	YES
a If yes, is it locked or in a safe and is the ammunition stored separately?	YES	NO
51 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO
52 Do you put sunscreen on your child when outside for a long time?	YES	NO
53 Do you have the number for Poison Control?	YES	NO
54 Is there a swimming pool, pond, or lake near your home?	NO	YES

Review of Systems

55 Do you have any concerns about your child's hearing?	NO	YES
56 Do you have any concerns about your child's vision?	NO	YES