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
Say 20-50 words?	Y	N
Combine 2 words?	Y	N
Throw ball overhand?	Y	N
Name pictures (cat, dog, bird, etc)?	Y	N
Follow 2 part command?	Y	N
Turn pages of book?	Y	N

M-CHAT-R (autism screen):

1. 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
2. Have you ever wondered if your child might be deaf?	Y	N
3. 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
4. like climbing on things like furniture, playground equipment or stairs?	Y	N
5. Does your child make unusual finger movements near his/her eyes? (wiggle his/her fingers close to his/her eyes?)	Y	N
6. 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
7. 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
8. interested in other children?(watch other children, smile at them or go to them)	Y	N
9. 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
10. 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
11. When you smile at your child, does he/she smile back at you?	Y	N
12. get upset by everyday noises? (scream/cry to vacuum cleaner/loud music)	Y	N
13. Does your child walk?	Y	N
14. look you in the eye when you are talking to, playing with or dressing him/her?	Y	N
15. copy what you do?(like wave bye-bye, clap or make funny noise)	Y	N
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Y	N
17. Does your child try to get you to watch him/her? (look at you for praise, or say “look” or “watch me”)	Y	N
18. 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
19. 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
20. like movement activities? (being swung or bounced on your knee)	Y	N