2 1/2 YEAR
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ______________________

Name: ______________________________________ DOB:___________ Male Female

Physician Signature:______________________________________

Instructions: Please answer the questions below about your child by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have any concerns about your child's health?	NO	YES
Any problems with previous immunizations?	NO	YES
Feeding/ Nutrition		
Is your child drinking milk?	YES	NO
How many ounces per day?		
What type of milk?		
Does your child have fruits or vegetables at every meal?	YES	NO
Are you giving your child mostly whole grains?	YES	NO
Does your family eat junk foods (chips, cookies, crackers,candy) or fast foods daily?	NO	YES
Does your child drink juice or other sweetened drinks?	NO	YES
Is your child taking any vitamins or supplements?	YES	NO
Lipids		
Have any parents or grandparents experienced a stroke or heart attack before age 55?	NO	YES
Do either parent have high cholesterol or are on cholesterol medication?	NO	YES
Oral Health		
Are cavities a problem for you or anyone in your family?	NO	YES
Are you using a soft toothbrush or cloth to clean child's teeth two times a day?	YES	NO
Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Do you have a dentist for your child?	YES	NO
Elimination		
Does your child have a daily soft bowel movement (poop)?	YES	NO
Do you have any questions about toilet training?	NO	YES
Activity/Exercise/Screen time		
Does your child watch TV or play video games more than 1 hour per day?	NO	YES
Is there a TV in your child's bedroom?	NO	YES
Do you read to your child every day?	YES	NO
Do you encourage family activities such as walking, bicycling, swimming, or dancing?	YES	NO
Do you do educational activities as a family, such as go to museums, zoos, or libraries?	YES	NO
Do you eat meals together as a family?	YES	NO
Sleep		
Does your child sleep through the night?	YES	NO
Do you have a bedtime routine?	YES	NO
Does you child fall asleep on their own in their own bed?	YES	NO
Does your child snore more than a little?	NO	YES

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Social Stressors		
Are you able to take some time for yourself?	YES	NO
Have you had any major changes or stresses in your family recently?	NO	YES
Do you ever worry your family will go hungry?	NO	YES
Do you have daycare concerns?	NO	YES
Does your partner ever hurt you or your children?	NO	YES
Behavior		
Does your child display excessive tantrums?	NO	YES
Do you have questions about discipline?	NO	YES
Do you praise your child when they are behaving well?	YES	NO
Do you give you child choices?	YES	NO
Development		
Does your child put three to four words together in a sentence?	YES	NO
Do others understand your child's speech half the time?	YES	NO
Does you child know eight or more body parts?	YES	NO
Do they know the correct animal sounds?	YES	NO
Can they brush their teeth with help?	YES	NO
Can they carry out a two-step command?	YES	NO
Can they jump with both feet off the floor?	YES	NO
Safety		
Do you watch your child when they are playing outside?	YES	NO
Do you keep your child away from vehicles, lawn mowers, driveways, and streets?	YES	NO
Does you child wear a helmet when on a tricycle or bicycle?	YES	NO
Is your child exposed to anyone who smokes?	NO	YES
Is there a gun in the home?	NO	YES
Is it locked or in a safe place?		
Does your home have working smoke detectors and carbon monoxide detectors?	YES	NO
Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO
Do you use sunscreen on your child for prolonged sun exposure?	YES	NO
Do you have the number for Poison Control?	YES	NO
Do you have a swimming pool, pond, or lake near your home?	NO	YES
Tuberculosis		
Has a family member or a contact had tuberculosis disease?	NO	YES
Has a family member had a positive TB skin test (PPD)?	NO	YES
Was your child born in a high-risk country (countries other that the U.S., Canada, Australia, or Western Europe?	NO	YES
Has your child traveled to a high-risk country for more than a week?	NO	YES
Review of Systems		
Do you have any concerns about your child's hearing?	NO	YES
Do you have any concerns about your child's vision?	NO	YES