Northwest PRIMARY CARE

3 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		
Does your child have fruits or vegetables at every meal?	○ YES	○ NO
Are you giving your child mostly whole grains?	○ YES	○ NO
Is your child drinking milk?	○ YES	○ NO
How much milk per day?		
What type of milk?		
Does your family eat junk foods (chips, cookies, crackers,candy) or fast foods daily?	○ NO	○ YES
Is your child taking any vitamins or supplements?	○ YES	○ NO
Does your child drink juice or other sweetened drinks?	○ NO	○ YES
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
School		
Is your child in preschool or childcare?	○ YES	○ NO
Activity/Exercise/Screen time		
Does your child watch TV or play video games more than 2 hours 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
Do you spend time alone with each of your children?	○ YES	○ NO
Do you spend time alone with your partner?	○ YES	○ NO
Sleep		
Do you have concerns about your child's sleep?	○ NO	○ YES
Does your child snore more than a little?	○ NO	○ YES

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Social Stressors		
Are you able to take a little 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 two to three sentences together?	○ YES	○ NO
Do others understand your child's speech, even non-family members?	○ YES	○ NO
Does you child count to five or more?	○ YES	○ NO
Does your child know two or more colors?	○ YES	○ NO
Does your child pretend play, such as using a telephone or playing house?	○ YES	○ NO
Does your child draw a person with two body parts?	○ YES	○ NO
Does your child walk up and down stairs alternating feet?	○ YES	○ NO
Can they feed themselves completely using a fork and spoon?	○ YES	○ NO
Can they throw a ball overhand?	○ YES	○ NO
Can they balance on one foot?	○ YES	○ NO
Are they toilet-trained during the day?	○ YES	○ NO
Can they name a friend?	○ YES	○ NO
Lead		
Are you living in a house built prior to 1978?	○ NO	○ YES
Is there any peeling or chipping paint?	○ NO	○ YES
Is there any recent, ongoing, or planning of remodeling?	○ NO	○ YES
Has a sibling or playmate ever had lead poisoning?	○ NO	○ YES
Safety		
Do you watch your child when they are playing outside?	○ YES	○ NO
Do you talk with your child about stranger safety?	○ YES	○ NO
Does your child know that private parts are private?	○ 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?	○ YES	○ NO
Is there a gun in the home?	○ NO	○ YES
If yes, is it locked or in a safe place?	○ YES	○ NO
Does your child ride in a safety seat, in the back seat?	○ YES	○ NO
Do you use sunscreen on your child for prolonged sun exposure?	○ YES	○ NO
Do you ever leave your child alone in the car, house, or yard?	○ NO	○ YES
Do you keep furniture away from windows or use window guards?	○ YES	○ NO

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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