2 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 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, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

6	Is your child drinking milk?	YES	NO
	a. What kind of milk?		
	b. How much milk per day?		
7	Does your child eat fruits or vegetables at every meal?	YES	NO
8	Do you feed your child mostly whole grains?	YES	NO
9	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
10	Does your child snack more than 2 times a day?	NO	YES
11	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
12	Is your child drinking from a bottle?	NO	YES
13	Does your child drink juice or other sweetened drinks?	NO	YES
14	Do you give your child any vitamins or supplements?	NO	YES
15	Are you worried about your child's weight?	NO	YES

Lipids

16	Does your child have parents or grandparents with stroke or heart attack before age 55?	NO	YES
17	Does your child have a parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

18	Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
19	Do you have a dentist for your child?	YES	NO
20	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

21	Does your child have regular soft bowel movements (poop)?	YES	NO
22	Have you started toilet (potty) training?	YES	NO
23	Does your child tell you when a diaper needs to be changed?	YES	NO

Activity / Exercise / Screen Time

24	Does your child have screen time (smartphone, tablet, TV) more than 1 hour daily?	NO	YES
25	Does your child have bedroom access to screen time?	NO	YES
26	Do you read to your child every day?	YES	NO
27	Does your child play actively for at least 1 hour per day?	YES	NO

Sleep

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

Social Stressors

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

Behavior

36 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
37 Do you praise your child when he/she is behaving well?	YES	NO

Development

(If you are completing the Ages and Stages questionnaire please skip this section)

38 Does your child have a fifty word vocabulary?	YES	NO
39 Does your child use 2-3 word phrases or sentences ("More milk" or "Hi Mom")	YES	NO
40 Does your child know 6 or more body parts?	YES	NO
41 Does your child copy things you do?	YES	NO
42 Does your child follow 2 step instructions?	YES	NO
43 Does your child walk up and down stairs while holding on?	YES	NO
44 Does your child turn pages one at a time?	YES	NO
45 Can your child name some pictures in books?	YES	NO
46 Can your child hold a cup with one hand?	YES	NO
47 Can your child jump with both feet on the floor?	YES	NO
48 Can your child throw a ball overhand?	YES	NO
49 Can your child kick a ball?	YES	NO
50 Does your child try to write with a pencil?	YES	NO

Lead

51 Is your child regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
52 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

53 Is the crib mattress at the lowest position?	YES	NO	
54 Does anyone smoke or vape around your child?	NO	YES	
55 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO	
56 Do you watch your child when he/she plays outside?	YES	NO	
57 Does your child wear a helmet when on a tricycle or bicycle?	YES	NO	
58 If there is a gun in the home, is it locked in a safe with the ammunition stored separately?	N/A	YES	NO
59 Does your child ride in a safety seat, in the back seat?	YES	NO	
60 Do you have the number for Poison Control?	YES	NO	
61 Do you put sunscreen on your child when in the sun for more than 15-30 minutes?	YES	NO	

Tuberculosis

62 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
63 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
64 Was your child born in a high-rick country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
65 Has your child traveled to a high-risk country for more than a week?	NO	YES