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 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

Question		
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

Question		
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

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

Activity/Exercise/Screen time

Question		
22 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
23 Does your child have bedroom access to any screen time?	NO	YES
24 Do you read to your child every day?	YES	NO

Sleep

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

Social Stressors

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

Behavior

34 Does your child have a lot of tantrums?	NO	YES
35 Do you have any questions about how to discipline your child?	NO	YES
36 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)

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

Lead

50 Is your child regularly in a house built before 1978?	NO	YES
a Is there any peeling or chipping paint?	NO	YES
b Has there been any recent or ongoing remodeling or do you plan to do any remodeling?	NO	YES
51 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

52 Is the crib mattress at the lowest position?	YES	NO
53 Does anyone smoke or vape around your child	NO	YES
54 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO
55 Do you watch your child when he/she plays outside?	YES	NO
56 Does your child wear a helmet when on a tricycle or bicycle?	YES	NO
57 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
58 Does your child ride in a safety seat, in the back seat?	YES	NO
59 Do you have the number for Poison Control?	YES	NO
60 Do you put sunscreen on your child when in the sun for more than 10 minutes?	YES	NO

Tuberculosis

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

Review of Systems

65 Do you have any concerns about your child's hearing?	NO	YES
66 Do you have any concerns about your child's vision?	NO	YES