



Health Maintenance Questionnaire

2 YEARS

Today's Date: _____

PATIENT NAME: _____

Birth Date: _____

PARENTS: _____

Age Today: _____

PARENTS' CONCERNS

List concerns you have: 1.
2.
3.
4.
5.

Please check any body areas that concern you:

- | | | | |
|---------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Heart | <input type="checkbox"/> Bones | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Joints | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestines | <input type="checkbox"/> Muscles | <input type="checkbox"/> Glands |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Brain | <input type="checkbox"/> Immunity |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Genitals | <input type="checkbox"/> Nerves | |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> Mental Health | |

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION

HISTORY	Describe any recent injuries or illnesses:
	List medications taken routinely: <input type="checkbox"/> none
	Note any new stresses in the family:
	Is your child in day care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Nanny How many kids in the room/home? _____
	Are there smokers in your baby's home or day care? <input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room
NUTRITION	Y N <input type="checkbox"/> <input type="checkbox"/> Has your child been to a dentist yet? Regular dentist appointments are recommended starting at 12 months old. Clean teeth regularly. Never allow a bottle in bed or continuous suckling during the night, as this contributes to cavities.
	How many ounces per day of Whole milk: _____ Juice: _____ How many servings per day of Meat: _____ Fruit: _____ Veggies: _____ Y N <input type="checkbox"/> <input type="checkbox"/> Are snacks scheduled? <input type="checkbox"/> <input type="checkbox"/> Is s/he starting to use a spoon and/or fork? <input type="checkbox"/> <input type="checkbox"/> Is your child off of the bottle? If no, how many bottles per day? _____
	If nursing, how many times per day? _____
	Y N <input type="checkbox"/> <input type="checkbox"/> Is your child showing any interest in toilet training? <input type="checkbox"/> <input type="checkbox"/> Does your child pass stools without problems?

- Avoid 2nd hand smoke.

FEEDING RECOMMENDATIONS

- May switch to 2% milk.
- Limit juices.
- Regular family meals.
- Avoid meal time battles
- Variable appetite at this age.
- Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins, gum.
- Breast feeding may be weaned gently and gradually when Mom and baby are ready.

TOILETING RECOMMENDATIONS

- Consider starting toilet training if ready. (longer dry periods, dislikes soiled diaper, words)
- Reward success and ignore failures.

PHYSICAL EXAM		Lab/Immunizations
Ht _____	Wt _____	HC _____
VS: _____		
ASSESSMENT		PLAN

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

Patient Name:

Birth Date:

Do you have concerns about your child's vision or hearing? Yes No

2 years

DEVELOPMENTAL ASSESSMENT

Yes No Are you concerned about your child's development?

M O T O R	Y N
	<input type="checkbox"/> <input type="checkbox"/> Do you encourage physical activities?
	<input type="checkbox"/> <input type="checkbox"/> Can your child climb up and down stairs 1 step at a time?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he jump?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he kick a ball?
	<input type="checkbox"/> <input type="checkbox"/> Can your child throw a ball overhand?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he open doors?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he stack 5 blocks?
	<input type="checkbox"/> <input type="checkbox"/> Does your child help with dressing?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he copy a straight or circular line?
L A N G U A G E	Y N
	<input type="checkbox"/> <input type="checkbox"/> Does your child say 20 words with meaning?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he say 2 word phrases?
	<input type="checkbox"/> <input type="checkbox"/> Are pronouns used (I, me, you), but sometimes incorrectly?
	<input type="checkbox"/> <input type="checkbox"/> Do you repeat his/her words using proper enunciation? (Unclear speech is normal between 2-4 years old.)
	<input type="checkbox"/> <input type="checkbox"/> Does your child follow 2 part commands?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he enjoy singing, nursery rhymes and counting?
	<input type="checkbox"/> <input type="checkbox"/> Do you read/look at picture books with your child everyday?
<input type="checkbox"/> <input type="checkbox"/> Do you limit TV to less than 2 hours per day?	
S O C I A L	Y N
	<input type="checkbox"/> <input type="checkbox"/> Does your child refer to self by name?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he imitate adults?
	<input type="checkbox"/> <input type="checkbox"/> Do you ask your child to help pick up toys?
	<input type="checkbox"/> <input type="checkbox"/> Does your child problem solve? (moves chair to counter)
	<input type="checkbox"/> <input type="checkbox"/> Is sharing difficult for him/her? (typical at this age)
	<input type="checkbox"/> <input type="checkbox"/> Do you arrange play time with other children?
	<input type="checkbox"/> <input type="checkbox"/> Do you provide musical and push toys?
	<input type="checkbox"/> <input type="checkbox"/> Does your child give hugs and kisses?
	<input type="checkbox"/> <input type="checkbox"/> Is your child curious about body parts? (normal)

BEHAVIOR RECOMMENDATIONS

Yes No Are you concerned about your child's behavior?

If these were reviewed previously, check this box.

Y N You may skip to the "Sleep" box.

Is your child becoming more independent? (normal)

Is your discipline consistent? (very important)

Do you show affection regularly?

Do you use time-in frequently? (praising good behavior)

Do you use time-out? (removing attention when doing unacceptable behavior)

Do you set limits and choose your battles wisely?

Do you try to give choices whenever it is reasonable?

Do you occasionally say "no"?

Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers?

Do you try to ignore tantrums? (very typical)

**S
L
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P**

Y N

Does your child sleep well?

Do you maintain a bedtime routine?

Does your child take naps OK? (variable number per day)

Are you considering the transition into a big bed?

Are you OK with your child's use of self-comforting behaviors?

thumb sucking pacifier

favorite object? None

Where does your child usually sleep?

SAFETY AWARENESS

Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Is the car seat placed appropriately in the back seat? SEE BELOW.	<input type="checkbox"/> <input type="checkbox"/> Is your child always closely supervised in the house and car?
<input type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control center's number handy?	<input type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on?
<input type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of reach?	<input type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage that may be hazardous?
<input type="checkbox"/> <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub?	<input type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child?
<input type="checkbox"/> <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets?	<input type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees?
<input type="checkbox"/> <input type="checkbox"/> Do you have window guards?	<input type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan?
<input type="checkbox"/> <input type="checkbox"/> Do you keep your doors locked?	<input type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly?
<input type="checkbox"/> <input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers?	<input type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach?
<input type="checkbox"/> <input type="checkbox"/> Do you monitor play near streets and driveways?	<input type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure?
	<input type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers?
	<input type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?

2019 Nebraska Car Seat law:

- Kids ride rear-facing at least until they turn 2. It is safest to stay rear-facing for as long as possible, until they reach the upper weight or height limit allowed by the car seat's manufacturer.**
 - Kids under age 8 must ride in a child safety seat, regardless of weight. NOTE: Once facing forward, use a car seat with a built-in harness for as long as your child fits in it. Then switch to a belt positioning booster seat.
 - Kids under age 8 must ride in the back seat, as long as there is a back seat with a seatbelt which is not already occupied by other children under age 8.
 - The above applies to childcare providers transporting children.
- Violation carries a \$25 fine plus court costs and 1 point is taken from the driving record.

TUBERCULOSIS (TB) RISK

Y N	TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> <input type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test?	
<input type="checkbox"/> <input type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America?	
<input type="checkbox"/> <input type="checkbox"/> Is anyone living in your house infected with HIV?	
<input type="checkbox"/> <input type="checkbox"/> Has your child been exposed to the following people: homeless, nursing home residents, institutionalized people, jail/prison inmates, illicit drug users, migrant farm workers.	
<input type="checkbox"/> <input type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?	

LEAD RISK

Y N	Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> <input type="checkbox"/> Does your child live in or visit a house built before 1978?	
<input type="checkbox"/> <input type="checkbox"/> Is there a sibling or playmate with lead poisoning?	
<input type="checkbox"/> <input type="checkbox"/> Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways?	
<input type="checkbox"/> <input type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead?	
<input type="checkbox"/> <input type="checkbox"/> Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?	

Child's Name:
Person completing this form:
Relationship to Child:

Date of Birth:
Today's date:

M-CHAT

Please fill out the following about your child's usual behavior, and try to answer every question.
If the behavior is rare, (you've only seen it once or twice), please answer as if your child does *not* do it.

-
- Yes No
 1. Does your child enjoy being swung, bounced on your knee, etc.?
- Yes No
 2. Does your child take an interest in other children?
- Yes No
 3. Does your child like climbing on things, such as up stairs?
- Yes No
 4. Does your child enjoy playing peek-a-boo/hide-and-seek?
- Yes No
 5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?
- Yes No
 6. Does your child ever use his/her index finger to point, to ask for something?
- Yes No
 7. Does your child ever use his/her index finger to point, to indicate interest in something?
- Yes No
 8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?
- Yes No
 9. Does your child ever bring objects over to you (parent) to show you something?
- Yes No
 10. Does your child look you in the eye for more than a second or two?
- Yes No
 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)
- Yes No
 12. Does your child smile in response to your face or your smile?
- Yes No
 13. Does your child imitate you? (e.g., you make a face - will your child imitate it?)
- Yes No
 14. Does your child respond to his/her name when you call?
- Yes No
 15. If you point at a toy across the room, does your child look at it?
- Yes No
 16. Does your child walk?
- Yes No
 17. Does your child look at things you are looking at?
- Yes No
 18. Does your child make unusual finger movements near his/her face?
- Yes No
 19. Does your child try to attract your attention to his/her own activity?
- Yes No
 20. Have you ever wondered if your child is deaf?
- Yes No
 21. Does your child understand what people say?
- Yes No
 22. Does your child sometimes stare at nothing or wander with no purpose?
- Yes No
 23. Does your child look at your face to check your reaction when faced with something unfamiliar?
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1999 Diana Robins, Deborah Fein, & Marianne Barton

