24 MONTH OLD

"I'm two! I understand almost everything you say. I have BIG feelings and need you to help me by setting limits and staying close by as I learn to regulate my feelings."

www.pedsnw.net

Patient Name: ____

Person Filling Out Form: ____

Relationship to Patient: ____

CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

yes no Does your child take any medications (daily or as needed)? If so, please list: ___________________
yes no Has your child had any reactions to medications?
yes no Is your child currently taking any vitamins, supplements, "alternative medicines", or therapies?
yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes no Is your child in day care?
yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes no Has a parent or household member ever had a problem with alcohol or drug use?
yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

yes no Is your child breastfeeding?
yes no Does your child take a bottle?
yes no Does your child use a sippy cup?
yes no Does your child drink anything other than milk and water? If so, what? ____________________
yes no Does your child eat food from all 4 food groups?
_________ How many times per week does your child eat fast food?

PREVENTIVE HEALTH

yes no Has your child seen a dentist in the past 6 months?
yes no Do you help your child brush their teeth twice daily?
yes no Does your child always ride in a 5 point harness car seat and in the backseat?
yes no Is your child watching more than 2 hours of screen time per day (TV, tablet, phone, movies, video games, etc.)?
yes no Does your child have outdoor time daily?
yes no Does your child use a helmet when using a bike or scooter or riding in a motorized toy?
yes no Do you live in a home built before 1960 (possible lead exposure)?
yes no Does a family member frequently work with lead (car batteries, making stain glass, etc.)?
yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
yes no Are there smoke alarms, fire extinguishers, and carbon monoxide alarms in your home?
yes no Have those alarms been checked in the past 12 months?
yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
yes no Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
yes no Was your child born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside the United States, Canada, Australia, New Zealand, or Western European countries)?
yes no Is your child enrolled in WIC?
On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes no Eyes (crossing, poor vision, etc.)
yes no Hearing
yes no Coughing, noisy or difficulty breathing, wheezing, or limitation in activity level
yes no Vomiting, stooling (diarrhea, constipation, or blood in the stools)
yes no Urination (change in frequency, or blood in the urine)
yes no Extremities (feet, legs, arms, hands)

M-CHAT-R™

pediatrics NORTHWEST PS
Mary Bridge Children's
www.pedsnw.net

Patient Name: ________________________ Date of Birth: ____________

Patient MRN: ________________________ Today's Date: ____________

Person Filling Out Form: ________________________ Relationship to Patient: ____________

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

Question		
1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believer? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset at everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

© 2009 Diana Robins, Deborah Fein, & Marianne Barton