2 Year Well Check-Up

Person completing form: Mother___ Father____ Grandparent____ Other _____

Parental Concerns: Do you have any concerns today? No__Yes__
IF YES, please explain_____

Relationships:
Who lives in the home with the child?_____
Number of siblings? _____
Does your child attend daycare? No____Yes____
Are you coping well with your child? No____Yes____
Are you comfortable with your child? No____Yes____
Over the past 2 weeks, have you felt down, depressed or hopeless? No____Yes____

Smoking:
Are there smokers at home? No____Yes____
If yes, do they smoke outside only? No____Yes____

TB Risk Assessment:
Known exposure to person with TB? No____Yes____
If yes, who? _____

Home Environment & Safety:
Type of dwelling: (circle one) Apartment House Trailer Other
Heat source: (circle one) Gas Electric Hot water Other
Water source for dwelling: (circle one) City/municipal Well
Known Lead exposure in home? No____Yes____
If yes, was it removed? No____Yes____
Home built before 1950? No____Yes____
Home built before 1978 with renovations in last 6 months? No____Yes____

Safety:
Child car seat forward facing in vehicle? No____Yes____
Does your dwelling have:
Carbon monoxide detectors? No____Yes____
Smoke detectors? No____Yes____
Pool/spa at home? No____Yes____
Pets or animals at home? No____Yes____
If yes, what types? _____
Firearms in the home? No____Yes____
If yes, are they in locked storage? No____Yes____

Sleep Habits:
Any concerns? No____Yes____
If yes, explain_____

Does your child take naps? No____Yes____
Does your child sleep in bed with parents? No____Yes____
Does your child sleep through the night? No____Yes____
Does your child sleep 8 hrs or more per night? No____Yes____
Any nightmares/night terrors? No____Yes____

Travel:
Any recent travel out of the country? No____Yes____
If yes, where did you travel? _____

Nutrition:
Does your child drink (circle all that apply): Milk Juice Water Soda
What type of milk is given?
Whole ___2%___1%___Soy ___Almond ___Rice____
How many ounces of milk per day? _____
How many ounces of juice per day? _____
Does your child drink from a cup? No____Yes____
Does your child eat a healthy variety of table foods? No____Yes____

Dental:
Any concerns with child's teeth? _____
Brushing teeth every day? No____Yes____
Has your child seen or are they scheduled to see a dentist? No____Yes____
Using a pacifier? No____Yes____

Elimination:
Any concerns with urine output? No____Yes____
Any concerns with bowel movements? No____Yes____
Is your child potty training? No____Yes____

Family History:
Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe _____
_____

Illness/Injuries/Hospitalizations/Surgeries:
Since the last well visit, has your child:
Had any injuries or admitted to the hospital? No____Yes____
Had any surgery? No____Yes____
If yes, please explain _____

*****See Back of Form*****

Developmental Milestones

	Not At All	Somewhat	Very Much
Names at least 5 body parts- like nose, hand or tummy ……	O	O	O
Climbs up a ladder at a playground……..	O	O	O
Uses words like “me” or “mine” ……..	O	O	O
Jumps off the ground with two feet…….	O	O	O
Puts 2 or more words together – like “more water” or “go outside”…….	O	O	O
Uses words to ask for help……..……	O	O	O
Names at least one color….	O	O	O
Tries to get you to watch by saying “Look at me” ……	O	O	O
Says his or her name when asked…..	O	O	O
Draws lines……..	O	O	O

Parent’s Observations of Social Interactions (POSI)

Does your child bring things to show them to you?

Many Times a Day	A Few Times a Day	A Few Times a Week	Less Than Once a Week	Never
O	O	O	O	O

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	O	O	O	O	O
When you say a word or wave your hand, will your child try to copy you?	O	O	O	O	O
Does your child look at you when you call his or her name?	O	O	O	O	O
Does your child look if you point to something across the room?	O	O	O	O	O

(Please check all that apply)

How does your child **Usually** show you something he or she wants?

Says a word for for what he/she wants	Points to it with one finger	Reaches for for it	Pulls me over or puts my hand on it	Grunts, cries or screams
O	O	O	O	O

What are your child’s favorite play activities?

Playing with dolls or Stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
O	O	O	O	O