

## Four Seasons Pediatrics

Well Visit Form for 18 month, 2 Year & 2 1/2 Year Well Visit

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Any change in address, if so list new information:

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### Feeding History:

How many ounces of milk does your child drink each day? \_\_\_\_\_

Does he/she eat most table foods? \_\_\_\_\_

Does he/she use a spoon and cup okay? \_\_\_\_\_

Is your child's teeth brushed every day? \_\_\_\_\_

Any problems with eating? \_\_\_\_\_

### Behavior:

Any problems with his/her sleeping? \_\_\_\_\_

Does your child have any difficult behavior you would like to change?

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Does your child have to be spanked frequently? \_\_\_\_\_

Is your family having any serious problems?

### Illnesses:

If your child is on medicines, name them: \_\_\_\_\_

Has your child had any serious illnesses since the last check up? \_\_\_\_\_

### Development:

**Please check the boxes to indicate if your 18 month old does the following:**

Scribbles with a crayon

Says about 10 words

Walks well

Uses a pull toy

Runs with legs stiff

Turns pages, 2-3 at a time

Can hurl a ball

**Please check the boxes to indicate if your 2 year old does the following:**

Puts 2-3 words together

Points to body parts

Can walk up stairs

Uses words: "I, me, you"

Can kick a large ball

Imitates you at home

Turns pages one at a time

Pulls up pants, puts on socks

**Please check the boxes to indicate if your 2 & 1/2 year old does the following:**

Imaginary play is increasing

Expressing fearfulness

Uses short phrases of 3-4 words

Is understandable to others 50% of the time

Has friends

Throws ball overhand

Brushes teeth with help

Puts on clothes with help

### Social:

Are both parents living at home? \_\_\_\_\_

Does your child brush his/her teeth every day? \_\_\_\_\_

Is your child taking fluoride? \_\_\_\_\_

### Screening – Please check the box if any of the following are true:

My child has had exposure to tuberculosis or a person with a positive skin test

My child spends a significant amount of time in a home built before 1960

There is a family history of high cholesterol of > 240 in either parent or grandparents

There is a family history of heart disease before 55 in either parent or grandparents

M-CHAT

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

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 dolls, 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 bricks) 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?  Yes  No

M-Chat reviewed and scored by: \_\_\_\_\_ Date: \_\_\_\_\_

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