

Four Seasons Pediatrics "

Well Visit Form for 3 Year Well Visit

Child's Name: _____ Birth Date: _____ Age: _____

Today's Date: _____

Any change in address, if so list new information:

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?

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 3 year old does the following:

Copies a circle

Dresses with supervision

Alternates feet up stairs

Unbuttons, slips on shoes

Rides a tricycle

Plays tag and other games

Knows full name, gender

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

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: _____
1999 Diana Robins, Deborah Fein, & Marianne Barton

Date: _____