Child Name: _____

Bright Futures Previsit Questionnaire
2½ Year Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please answer all of the questions. Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Routines	☐ Setting limits on your child's behavior ☐ All caregivers using the same rules with your child ☐ Your child's weight ☐ Doing fun things as a family ☐ Day and evening routines ☐ Eating together as a family
Learning to Talk and Communicate	☐ How much TV is too much TV ☐ Your child's speech
Getting Along With Others	☐ Playing well with others ☐ How and why to give your child choices
Getting Ready for Preschool	☐ Is your child ready for preschool ☐ Playgroups ☐ Toilet training
Safety	☐ Car safety seats ☐ Staying safe near water ☐ Playing safe outside ☐ Preventing sunburns ☐ Preventing fires ☐ Staying safe with your pets and others

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: ☐ Yes ☐ No ☐ Unsure

_____

_____

Hearing	Do you have concerns about how your child hears?	☐ Yes	☐ No	☐ Unsure
	Do you have concerns about how your child speaks?	☐ Yes	☐ No	☐ Unsure
Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure
	Does your child hold objects close when trying to focus?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	☐ Yes	☐ No	☐ Unsure
	Have your child's eyes ever been injured?	☐ Yes	☐ No	☐ Unsure
Oral Health	Does your child have a dentist?	☐ No	☐ Yes	☐ Unsure
	Does your child's primary water source contain fluoride?	☐ No	☐ Yes	☐ Unsure

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes?

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have specific concerns about your child's development, learning, or behavior? ☐ No ☐ Yes, describe:

_____

_____

Check off each of the tasks that your child is able to do.

- ☐ Points to 6 body parts
- ☐ Jumps up and down in place
- ☐ Puts on clothes with help
- ☐ Other people can understand what your child is saying half the time
- ☐ Washes and dries hands without help
- ☐ Plays pretend
- ☐ Plays with other children, like tag
- ☐ When talking, puts 3 or 4 words together
- ☐ Knows correct animal sounds (such as cat meows, dog barks)
- ☐ Brushes teeth with help

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

*** CONTINUE TO BACK FOR IMPORTANT HEALTH AND SAFETY QUESTIONS ***

Westerville Pediatric Specialists, Inc.

Child Name: _____

The questions below are to be answered by PARENT/LEGAL GUARDIAN.

HEALTH AND SAFETY

We are devoted to the health and safety of you and your family. Please tell us how comfortable you feel with the following necessities:

I have enough **MONEY** to provide for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide **FOOD** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide **HOUSING** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide or arrange **TRANSPORTATION** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

M-CHAT

The American Academy of Pediatrics recommends identifying infants and young children with developmental disorders. Therefore, M-Chat screenings should be completed on all children at the age of 18 months & 2 ½ years.

I, _____ give my consent for my child
Parent's Name (printed)

_____, to have the M-Chat screening performed by
Child's Name (printed)

Westerville Pediatric Specialists, Inc.

I **ACCEPT** M-Chat screening at this time for my child.

Date _____ Signature _____

I **DECLINE** M-Chat screening at this time for my child.

Date _____ Signature _____

M-CHAT-R™

Child's Name:

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 check **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (i.e. 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-believe? (i.e., 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? (i.e., furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his/her eyes? (i.e., does your child wiggle her/her fingers close to her/her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (i.e., 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? (i.e., pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (i.e., 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? (i.e., showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call him/her name? (i.e., does she/she look up, talk or babble, or stop what she/she is doing when you call her/her name?)	Yes	No
11. When you smile at your child does he/she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (i.e., 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/her, playing with him/her or dressing him/her?	Yes	No
15. Does your child try to copy what you do? (i.e., 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/her? (i.e., 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/her to do something? (i.e., 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? (i.e., if she/she hears a strange or funny noise, or sees a new toy, will she/she look at your face?)	Yes	No
20. Does your child like movement activities? (i.e., being swung or bounced on your knee?)	Yes	No

Physician Signature: Date: