

30 Month (2.5 years) Questionnaire

Patient's Name: \_\_\_\_\_

**Personal/Social History**

*Are you concerned about your child's...*

- 1. Bowel movements.....  Yes  No
- 2. Congestion or wheezing? .....  Yes  No
- 3. Skin color or rashes (circle one)? .....  Yes  No
- 4. Overall development? .....  Yes  No
- 5. Communication skills? .....  Yes  No
- 6. Lack of interest in toilet training? .....  Yes  No

*Answer the following:*

- 7. Is your child exposed to cigarette smoke?.....  Yes  No
- 8. Were there any problems with immunizations in the past? .....  Yes  No
- 9. Have you been sad, depressed or crying excessively?.....  Yes  No
- 10. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year?.....  Yes  No
- 11. Does your child eat non-food substances such as paint chips? .....  Yes  No
- 12. Is your water source from a well?.....  Yes  No

*Does your child...*

- 13. Speak in sentences? .....  Yes  No
- 14. Become shy or anxious with strangers? .....  Yes  No
- 15. Feed him/herself with a spoon? .....  Yes  No
- 16. Show an imagination?.....  Yes  No
- 17. Sit for a book to be read?.....  Yes  No
- 18. Repeat words well? .....  Yes  No
- 19. Show pretend play? .....  Yes  No
- 20. Run well? .....  Yes  No
- 21. Climb?.....  Yes  No
- 22. Try to engage you with their eyes and gestures to communicate their needs? .....  Yes  No
- 23. Jump with both feet off of the floor? .....  Yes  No
- 24. Try to color with a crayon? .....  Yes  No

*Answer the following:*

- 25. Do you have smoke alarms? \_\_\_\_\_ Carbon monoxide detectors? \_\_\_\_\_
- 26. Does your child ride in a forward-facing infant safety seat?.....  Yes  No
- 27. Do you know infant CPR? .....  Yes  No
- 28. September through March visits: Have all caregivers and family members living in the home been vaccinated for the flu this season? .....  Yes  No
- 29. Are you giving your child a multivitamin with iron? .....  Yes  No
- 30. Is your child eating all food groups: fruits, meats, and vegetables? .....  Yes  No
- 31. Is your child off the bottle and on to a sipper cup with a hard plastic nipple? .....  Yes  No
- 32. Are you brushing your child's teeth? .....  Yes  No
- 33. How many ounces of milk does your child drink in one day? \_\_\_\_\_ What kind? \_\_\_\_\_
- 34. How many ounces of juice does your child drink in one day? \_\_\_\_\_
- 35. Have you switched to low fat or skim milk?.....  Yes  No

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Screening questions for Tuberculosis:

- 1. Do you have a family member with TB or any contact with someone who has TB?.....  Yes  No
- 2. Do any family members have a positive TB test? .....  Yes  No
- 3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? .....  Yes  No
- 4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? .....  Yes  No
- 5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? .....  Yes  No

Lead Screening:

*Does your child...*

- 1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) .....  Yes  No
- 2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? .....  Yes  No
- 3. Have a sibling or playmate who now has or did have lead poisoning? .....  Yes  No
- 4. Is your child a refugee from another country? .....  Yes  No
- 5. Does your child have their health insurance provided by Medicaid or INtotal Health?  Yes  No

Name and Ages of Brothers \_\_\_\_\_  
 Sisters \_\_\_\_\_

Patient lives with: Mom \_\_\_\_\_ Dad \_\_\_\_\_ Both Together \_\_\_\_\_ Both Separately \_\_\_\_\_

*Do you have any concerns you wish to discuss? .....*  Yes  No

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Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relationship to child \_\_\_\_\_

**M-CHAT-R™** (Modified Checklist for Autism in Toddlers Revised)

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.

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-believe? (**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 by 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