

Your Child's 2 Year Well-Visit

Child's Name _____

Child's Date of Birth _____

This form will help us give your child the best care possible. We will use it to focus the visit on the information you would like to receive.

This tool was developed by the Child and Adolescent Health Measurement Initiative (CAHMI). Visit www.wellvisitplanner.org or contact cahmi@ohsu.edu for further information.

Your Name: _____ Your relationship to the child: _____

Share with me one thing that **your child is able to do** that you are excited about: _____

Are there any specific **concerns** you want to discuss today? No Yes _____

Have there been any **major** changes in your family lately? None Move Job Change Separation Divorce
 Death in the family Other? Describe: _____

GENERAL HEALTH INFORMATION	Yes	No
Since your last visit, has your child had any major illnesses and/or hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a bad reaction to a vaccine (temp>104, inconsolable crying>3 hours)?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your child's relatives developed new medical problems since the last visit?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child live with both parents in the same home?	<input type="checkbox"/>	<input type="checkbox"/>
Do any adults who are around your child smoke? (includes inside or outside the house)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dentist for your child?	<input type="checkbox"/>	<input type="checkbox"/>
In the past two weeks, how often have you been bothered by any of the following problems: Little interest or pleasure in doing things? <input type="checkbox"/> Nearly every day <input type="checkbox"/> More than half the days <input type="checkbox"/> Several days <input type="checkbox"/> Not at all Feeling down, depressed or hopeless? <input type="checkbox"/> Nearly every day <input type="checkbox"/> More than half the days <input type="checkbox"/> Several days <input type="checkbox"/> Not at all		
In general, how well do you feel you are coping with the day-to-day demands of parenthood? <input type="checkbox"/> Not well at all <input type="checkbox"/> Not very well <input type="checkbox"/> Somewhat well <input type="checkbox"/> Well <input type="checkbox"/> Very well		

PICK YOUR PRIORITIES: UP TO FIVE Tell us what you want to talk about today by checking up to **5** boxes **TOTAL** from the topics below (fewer than 5 is OK, too). Find information on the topics below at www.wellvisitplanner.org/education.

Promoting Language Development

- Words & phrases your child uses & understands
- Importance of using simple words, asking simple questions & repeating what your child said
- Ways to read to your child to promote language development

TV Watching & Physical Activity

- Television - how much is okay?
- Importance of outside family activities that involve playing, walking, running, or playing chase
- A healthy weight for your child

Your Child's Health & Behavior

- Behaviors to expect in the next few months
- Ways to guide & discipline your child
- Giving your child a choice between 2 options
- How your child reacts in new situations
- Play-groups & how your child gets along with others
- Your child's moods & emotions
- Issues related to preschool
- Alternative/natural care therapies or products you may use with your child

Other

Toilet Training

- Signs your child is ready to potty train
- Helping your child potty train
- Teaching your child good hygiene

Your Child's Safety

- Preventing injuries indoors & outdoors
- Installing car seat correctly/when to use a booster seat
- Setting a positive example by always using your seatbelt
- Importance of your child wearing a helmet
- Bathtub, water & pool safety
- Gun safety at home & other places

YOUR GROWING AND DEVELOPING CHILD

Do you have any specific concerns about your child's learning, development or behavior? Not at all A little A lot
Describe: _____

Do your child's eyes appear unusual or seem to cross, drift or be lazy? Yes No

Do you have any concerns about how your child hears? Yes No

Please check each task your child is able to do right now.

Gross Motor

- Walk up stairs one at a time (holding one of your hands, the wall, or a handrail)
- Kick a ball forward
- Jump in place both feet together
- Throw a ball overhand

Fine Motor

- Stack 4 small blocks or toys on top of each other
- Stack 8 small blocks or toys on top of each other

Social/Emotional

- Remove his/her clothing
- Dress himself/herself

Cognitive/Communicative

- Point to two pictures that you name (such as cat, horse, bird, or man)
- Use at least two words together (such as "big dog")
- Name 1 picture (such as cat, horse, bird, or man)