

30 Month Visit (2 1/2 Years)

NAME

DATE

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

1. Nutrition or eating habits?	YES	NO
2. Bowel movements?	YES	NO
3. Frequent infections?	YES	NO
4. Skin color or rashes?	YES	NO
5. Interest in toilet training?	YES	NO
6. Discipline?	YES	NO
7. Communication?	YES	NO
8. Sleep habits?	YES	NO
9. Development?	YES	NO

Does your child.....

1. Imitate adults?	YES	NO
2. Pretend play?	YES	NO
3. Play alongside other children?	YES	NO
4. Refer to self as "I" or "me"?	YES	NO
5. Established attachment to a transitional object? (teddy bear, etc)	YES	NO
6. Have a vocabulary of 50 words?	YES	NO
7. Use 2 word phrases?	YES	NO
8. Ask a parent to read a book?	YES	NO
9. Follow a 2-step command?	YES	NO
10. Name one picture, such as cat,dog, bird, horse, man?	YES	NO
11. Complete sentences and rhymes in familiar books?	YES	NO
12. Respond to "where is _____?" by pointing to a picture in a book.	YES	NO
13. Stack 5 or 6 objects?	YES	NO
14. Imitate horizontal and circular strokes with a crayon?	YES	NO
15. Turn pages in a book one at a time?	YES	NO
16. Throw a ball overhand?	YES	NO
17. Kick a ball?	YES	NO
18. Jump up?	YES	NO
19. Walk up and down stairs one step at a time?	YES	NO
20. Have exposure to a gun in the house? YES NO If so, locked?	YES	NO
21. Live in a smoke free environment?	YES	NO
22. Live in a house with poisons and toxic household chemicals out of reach?	YES	NO
23. Sit in a car seat, restrained? If so, facing Front or Rear?	YES	NO

LEAD Screen (Pb)

1. Does your child live in or regularly visit a house built before 1950?	YES	NO
2. Does your child live in or visit a house built before 1978 with recent remodeling or renovation? (within 6 months)	YES	NO
3. Have a sibling or playmate who now or did have lead poisoning?	YES	NO

over

Tuberculosis Screen (TB)

- | | | |
|--|-----|----|
| 1. Has a family member or contact had tuberculosis disease? | YES | NO |
| 2. Has a family member had a positive TB test? | YES | NO |
| 3. Was your child born outside the US, Canada, Australia, New Zealand or Western Europe? | YES | NO |
| 4. Has your child traveled to a high risk country for more than 1 week? | YES | NO |

Do you have any other concerns you wish to discuss? YES NO

Office use only

WT HT HC BMI % tile BP