CASTLE VALLEY CHILDRENS' CLINIC

Health Maintenance Visit

2 Year - 3 Year

Patient Name_____

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO THE DOUBLE LINE (please circle and check appropriate answers

NUTRITION (Subjective)

1. Parent: How many servings of each of the 4 food groups does your child eat each day?

Please write number of servings in space provided after review examples of serving size for this age group.

MILK	**MEAT**	**FRUITS AND VEGETABLES**	**GRAINS**
1/2 - 3/4 cup milk	1/2 sm hamburger or 1/4 cup tuna	2 -3 Tbsp cooked fruit or vegetable	3/4 slice bread
1/2 - 3/4 cup yogurt	1/2 drumstick	1/2 cup raw fruit or vegetable	1/2 cup cold cereal
3/4 cup ice cream	1 egg or 1 slice meat		1/4 cup cooked cereal
2/3 cup cottage cheese	3 Tbsp nuts, sunflower seeds or		4 graham crackers
1 oz cheese	peanut butter		1/4 cup rice, potatoes, or noodles
_____# of servings my child eats each day	_____# of servings my child eats each day	_____# of servings my child eats each day	_____# of servings my child eats each day

2. List snack foods _____

3. Are there table foods your child will not eat?	yes	no
4. How many glasses of each does your child drink each day? milk _____ water _____		
5. Does your child use a spoon and cup?	yes	no
6. Does your child have any problems with eating?	yes	no
7. Is your child on WIC or Denver Food Supplemental Program?	yes	no
8. Do you brush your child's teeth everyday with a fluoride toothpaste?	yes	no

ELIMINATION

9. Does your child have pain with urination, frequent urination, weak or dribbling stream, strong or funny smell of urine?	yes	no
10. Does your child experience constipation, diarrhea, worms itching around rectum, or bleeding from bowels?	yes	no

BEHAVIOR

11. Does your child have any problems with sleeping?	yes	no
12. Your child sleeps from _____ pm to _____ am Number of naps _____		
13. Does your child have any behaviors you would like to change?	yes	no
14. What do you do when your child doesn't mind? _____		
15. Does your child spend time with other children?	yes	no

DEVELOPMENT

16. All children learn things at different times. At this point in your child's development, check which of the following he/she can do.

_____ Walk downstairs without help	_____ Pedal a tricycle	_____ Kick a ball
_____ Throw a ball overhead	_____ Wash his/her own hands	_____ Color and scribble
_____ Build a tower of four blocks	_____ Follow directions such as "give me"	_____ Put on clothing

17. I feel my child's development is: NORMAL _____ ABNORMAL_____

ILLNESS

18. If your child is on any medications, name them: _____

19. Has your child had any serious illnesses or needed to see a doctor since the last checkup?	yes	no

REVIEW OF SYSTEMS (Check if your child has any of the following since the last visit.)

____ Headaches	____ Strep sore throats	____ Cannot keep up with friends	____ Loses balance
____ Head injury or unconsciousness	____ Teeth problems/sore gums	when playing	____ Allergies
____ Convulsion or seizures	____Thumbsucking	____ Skin rashes or other problems	____ Heart murmur
____ Ear infections or earaches	____ Speech problems	____ Frequent colds or coughing	____ Depression
____ Hearing problems	____ Swollen glands	____ Stomach pains	____ Recent weight gain or loss
____ Crossed eyes/vision problems	____Wheezing or trouble	____ Recent change - home/family	____ Anemia
____ Persistent nosebleeds	breathing	____ Broken bones or sprains	____ Accidents/injuries
____ Frequent nasal congestion	Turning blue	Swollen or painful joints/limping	

OBJECTIVE:

NURSING DIAGNOSIS:

PLAN: (Anticipatory guidance checklist on page 1)

PROVIDER SIGNATURE _____

M-CHAT-R™

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