

**Your child is 2 years old!**

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
<input type="checkbox"/> Well Visit <input type="checkbox"/> Allergies <input type="checkbox"/> Cold/flu <input type="checkbox"/> Constipation <input type="checkbox"/> Cough <input type="checkbox"/> Development <input type="checkbox"/> Earache <input type="checkbox"/> Fever <input type="checkbox"/> Growth/nutrition <input type="checkbox"/> Injury <input type="checkbox"/> Rash <input type="checkbox"/> Red eyes <input type="checkbox"/> Sore throat <input type="checkbox"/> Speech <input type="checkbox"/> Temper <input type="checkbox"/> Vaccines <input type="checkbox"/> Vomiting <input type="checkbox"/> Other (please explain): _____	
Health Changes	
Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nutrition, Feeding and Supplements – Tell us about what your child eats.	
My child eats a variety of fruits and/or vegetables over the course of a week:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child has a daily source of iron in their diet, like meat or beans:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any other vitamins, supplements, or over-the-counter medicines you give your child: _____	
Dental Health	
Has your child seen a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.	
<b>My child:</b>	
Knows at least 50 words, including 5 body parts:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses 2-word phrases:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Follows 2-step directions:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Talks so a stranger would understand at least half of their speech:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses 1 foot per step when going up stairs or climbing a ladder:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jumps with two feet:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kicks a ball:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses a utensil to feed themselves:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Turns lids, pages, and doorknobs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can draw a line:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enjoys playing around other children:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enjoys showing me things	<input type="checkbox"/> Yes <input type="checkbox"/> No
Looks at things if I point at them:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plays pretend and imitates:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is easy to console, and not aggressive or anxious:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses screens (TV/phone/tablet/computer) for 1 hour per day or less:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Only views screen content chosen by me or another adult:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you read to your child daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your family enjoy physical activities outdoors with your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Safety</b>	
My child uses a car seat with a 5-point harness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
We have gates across stairs and safety guards on windows:	<input type="checkbox"/> Yes <input type="checkbox"/> No
We have cleaning supplies, medicines, and matches locked away:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets):	<input type="checkbox"/> Yes <input type="checkbox"/> No
The buildings where my child lives or regularly visits were built after 1978 or, if built before 1978, have not been renovated in the past 6 months and do not have peeling paint:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Our furniture is bolted to the wall to prevent tipping:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My home has smoke detectors:	<input type="checkbox"/> Yes <input type="checkbox"/> No
There are guns in our home or in other homes where my child visits:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
If Yes, are all guns stored unloaded and locked away, with ammunition locked away separately?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
<b>Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.</b>	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your plan for childcare? <input type="checkbox"/> Home with parent <input type="checkbox"/> Family member <input type="checkbox"/> Nanny or Sitter <input type="checkbox"/> Childcare center	
Do you need assistance finding affordable and safe childcare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is there anyone who lives in your home or cares for your child who:</b>	
– Smokes or vapes tobacco or marijuana:	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Uses prescription pain medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Uses other drugs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Within the past 12 months, have you:</b>	
– Run out of food or been worried your food would run out before there was money to buy more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Worried about housing or had to move?	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Had difficulty getting other supplies and services you need to care for your child? Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	<input type="checkbox"/> Yes <input type="checkbox"/> No