

Your child is 3 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: | |
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| <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): _____ | |
| Briefly describe your concern: _____ | |
| 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. | |
| My child: | |
| Uses short sentences with at least 3 words, and tells me stories: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Talks so a stranger can understand 75% of their speech: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Uses alternate feet, like when climbing stairs or pedaling a bike: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Draws: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Enjoys pretending in their play, like dress-up: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is easy to console, and not violent, aggressive, or anxious: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is toilet trained (for pee and poop): | <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 |

| Safety | |
|--|---|
| 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 |
| 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 |
| My child wears a helmet when on a bicycle, scooter, or other wheeled toy: | <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 |
| 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. | |
| 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 <input type="checkbox"/> Preschool | |
| Do you need assistance finding affordable and safe childcare? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have concerns about safety in your home? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you concerned your child has been exposed to violence or abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is there anyone who lives in your home or cares for your child who: | |
| – 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 |
| Within the past 12 months, have you: | |
| – 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 car seat, bicycle helmet, hot water, electricity, and transportation. | <input type="checkbox"/> Yes <input type="checkbox"/> No |