

Complete for Ages 0-2 years

Name: **Your Overall Feeling**  Excellent  Very Good  Good  Fair  Poor  
 Do you have any specific concerns today?  
 Is patient or parent currently in a situation where they are being verbally or physically hurt, threatened or made to feel afraid?  Yes  No  
 Does your child have any of these symptoms at the present time:

<input type="checkbox"/> Fever	<input type="checkbox"/> Pulling at Ears	<input type="checkbox"/> Cough	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rash
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Vision Concerns
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Sore Throat (over age 2)	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Hearing Concerns

Please list all medications (including OTC, Herbs, and Supplements) \_\_\_\_\_  
 Please list allergies (drug, food, latex) \_\_\_\_\_  
 No Allergies

Are you enrolled in RELAYHEALTH so that you can e-mail your provider?  Yes  No  
 Please provide your e-mail so we can enroll you in Relay Health: \_\_\_\_\_

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Lead Questionnaire
<p>In the age group below that is closest to your child's age, please check the actions your child does:</p> <p><b>0-1 Month</b></p> <input type="checkbox"/> Eats Well <input type="checkbox"/> Follows faces <input type="checkbox"/> Turns to voice <input type="checkbox"/> Calms to voice <input type="checkbox"/> Sucks, swallows and breathes without difficulty <input type="checkbox"/> Fixes on faces <input type="checkbox"/> Lifts chin off surface <input type="checkbox"/> Can be calmed <input type="checkbox"/> Starting to smile <p><b>2 MONTHS</b></p> <input type="checkbox"/> Starting to smile <input type="checkbox"/> Coos <input type="checkbox"/> Different cry for different needs <input type="checkbox"/> Looks for parent <input type="checkbox"/> Lifts head and chest off surface <input type="checkbox"/> Head steady in upright position <input type="checkbox"/> Decreased newborn reflexes <input type="checkbox"/> Can indicate boredom <input type="checkbox"/> Calms self <p><b>4 MONTHS</b></p> <input type="checkbox"/> Has a social smile <input type="checkbox"/> Head steady in upright position <input type="checkbox"/> Responds to affection <input type="checkbox"/> Elicits attention <input type="checkbox"/> Indicates pleasure and displeasure <input type="checkbox"/> Reaches for objects <input type="checkbox"/> Calms self <input type="checkbox"/> Rolls from front to back <input type="checkbox"/> No head lag when pulled to sit position <input type="checkbox"/> Uses arms to push chest off surface <p><b>6 MONTHS</b></p> <input type="checkbox"/> Rolls from front to back <input type="checkbox"/> Makes vowel sounds <input type="checkbox"/> Enjoys vocal turn-taking <input type="checkbox"/> Enjoys personal interaction <input type="checkbox"/> Rolls from Back to Front <input type="checkbox"/> Sits briefly leaning forward <input type="checkbox"/> Visually explores surroundings <input type="checkbox"/> Responds to Own Name <p><b>9 MONTHS</b></p> <input type="checkbox"/> Sits independently <input type="checkbox"/> Crawls/creeps <input type="checkbox"/> Shy with Strangers <input type="checkbox"/> Seeks parent for comfort <input type="checkbox"/> Looks at books <input type="checkbox"/> Points out objects <input type="checkbox"/> Object permanence- object still exist even though not seen <input type="checkbox"/> Imitates sounds <p><b>30 MONTHS</b></p> <input type="checkbox"/> Plays "pretend" <input type="checkbox"/> Jumps in place <input type="checkbox"/> Points to 6 body parts <input type="checkbox"/> Brushes teeth with help <input type="checkbox"/> Washes and dries hands <input type="checkbox"/> Dresses with supervision <input type="checkbox"/> Uses 2-3 word sentences <input type="checkbox"/> Knows correct animal sounds <input type="checkbox"/> Plays interactively with other children <input type="checkbox"/> Other people understand half of spoken words			

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Lead Questionnaire
<p>In the age group below that is closest to your child's age, please check the actions your child does:</p> <p><b>12 MONTHS</b></p> <input type="checkbox"/> Babbles <input type="checkbox"/> Plays peek-a-boo <input type="checkbox"/> Pulls self to standing position <input type="checkbox"/> Waves bye-bye <input type="checkbox"/> Imitates simple daily tasks <input type="checkbox"/> Offers a book to read <input type="checkbox"/> Drinks from a cup <input type="checkbox"/> Imitates sounds <input type="checkbox"/> Follows gaze <input type="checkbox"/> Cries when you leave <input type="checkbox"/> Stands well alone <input type="checkbox"/> Bangs objects together <input type="checkbox"/> Mama/Dada Specifically <p><b>15 MONTHS</b></p> <input type="checkbox"/> Walks Unassisted <input type="checkbox"/> Tries to do what parents do <input type="checkbox"/> Understands and follows simple commands <input type="checkbox"/> Drinks with minimal spilling <input type="checkbox"/> Listens to a story <input type="checkbox"/> Brings and shows a toy <input type="checkbox"/> Scribbles <input type="checkbox"/> Vocabulary of 3-6 words <input type="checkbox"/> Helps with simple tasks <p><b>18 MONTHS</b></p> <input type="checkbox"/> Points to body on request <input type="checkbox"/> Drinks with minimal spilling <input type="checkbox"/> Stacks two blocks <input type="checkbox"/> Helps with simple tasks <input type="checkbox"/> Uses spoon with minimal spilling <input type="checkbox"/> Names favorite book <input type="checkbox"/> Laughs in response to others <input type="checkbox"/> Vocabulary of 7-20 words <input type="checkbox"/> Walks up steps <input type="checkbox"/> Runs <p><b>24 MONTHS</b></p> <input type="checkbox"/> Tries to do what parents do <input type="checkbox"/> Combines two different words <input type="checkbox"/> Names an animal in a picture <input type="checkbox"/> Kicks a ball forward <input type="checkbox"/> Plays "pretend" <input type="checkbox"/> Parallel play (alongside children) <input type="checkbox"/> Stacks 5 or more blocks <input type="checkbox"/> Follows 2-step commands <input type="checkbox"/> Turns single pages <input type="checkbox"/> Jumps in place <input type="checkbox"/> Walks up and down stairs <input type="checkbox"/> Throws ball overhand <input type="checkbox"/> Plays interactively with other children			