PT ID: _____ Patient's Name: _____

PCP: _____ Date of Birth: _____

Today's Date: _____

3 Year Old Parent Observations

Are there any concerns you would like to discuss today? _____

_____

Diet/Sleep:

Any concerns about diet or weight gain/growth? .....YES NO

Does your child eat well? (i.e. has consistent appetite, not too picky) .....YES NO

- What does your child drink? _____
- If picky, what does your child dislike? _____

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) .....YES NO

Is your child showing interest in potty training? ..... YES NO

- If trained: (check all that apply) ☐Day ☐Night ☐Urine ☐Stool

Any concerns about sleep? ..... YES NO

Development:

Do you read to your child every day? ..... YES NO

How much screen time (TV/tablet/phone) does your child have per day? _____

Do you have any concerns about your child's hearing or vision? ..... YES NO

Any concerns about your child's development? ..... YES NO

Does your child: (check all that apply)

☐ draw a circle	☐ pedal a bike	☐ use complete sentences
☐ know 3 colors or shapes	☐ alternate feet up stairs	☐ 75% speech is understandable
☐ stack 6-8 blocks	☐ throws overhand	☐ copies adults
☐ count to 3	☐ stand/hop on one foot	☐ knows age/gender
☐ name a friend	☐ dress him/herself	☐ participate in interactive play

Social/Behavior:

If parent(s) work, who cares for your child? _____

Are there any family or social issues you would like to discuss? .....YES NO

Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? .....YES NO

Does your child play/socialize well with other children? .....YES NO

Does your child receive consistent discipline/teaching/setting limits? .....YES NO

Does your child have a routine or stable schedule most days? .....YES NO

Safety/Preventative Health:

Are you brushing your child's teeth with a smear of fluoride toothpaste? .....YES NO

Has your child seen a dentist? ..... YES NO

Is your home/car a smoke-free environment? ..... YES NO

Does your child use a car seat 100% of the time? ..... YES NO

*** A child should be rear-facing as long as possible, until they reach the highest weight or height allowed by their seat***

Are your child's immunization up to date? .....YES NO

Does your child have any allergies (that you know of)? ..... YES NO

Please list any medications or supplements your child took this week: _____