



PT ID: _____

PCP: _____

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

2 Year Old Parent Observations

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

Diet/Sleep:

Any concerns about feedings or weight gain?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

Any concerns about sleep? YES NO

Development:

Do you read to your child every day? YES NO

Does your child watch TV/tablet/phone/have other screen time? YES NO
(if yes, how much screen time per day? _____)

Do you have 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)

- scribble well, kick a ball, use 2 word phrases, participate in parallel play, draw a line, walk down stairs, imitate chores, play make believe, stack 5-6 blocks, copy a circle, use 50 words, follow 2-step commands

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

Any illnesses or fevers in the last 24 hours? 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: _____