PT ID: ___________________
PCP: ____________________
Today's Date: ____________

Patient's Name: ___________________________
Date of Birth: _____________________________

4 Year Old Parent Observations

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

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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 potty trained: (check all that apply) ☐ Day ☐ Night ☐ Urine ☐ Stool
Does your child have any problems with 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	☐ catch bounced ball	☐ know first/last name
☐ stack 8+ blocks	☐ count to 5-10	☐ know shapes/colors
☐ hop	☐ use complete sentences	☐ pretend play
☐ stand on one foot	☐ speak 100% understandably	☐ participate in cooperative 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 receive consistent discipline/teaching/setting limits? ....YES NO

Safety/Preventative Health:

Does your child use a car seat or booster 100% of the time? .... YES NO
Is your home/car a smoke-free environment? .... YES NO
Are you brushing your child's teeth with fluoride toothpaste? .... YES NO
Has your child seen a dentist? .... YES NO
Does your child participate in regular physical activity? (about 1hr play/sport) .... YES NO
Does your child always wear a helmet when riding bike/scooter/skiing/etc? .... YES NO
Have you discussed "stranger danger" with your child? .... YES NO
Have you discussed trampoline/water safety with your child? .... YES NO
Do you own a gun? YES NO If yes, is it stored safely (i.e. locked case)? .... YES NO

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: ____