24 Month (2 year) Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your child's…

1. Bowel movements ..... ☐ Yes ☐ No
2. Congestion or wheezing? ..... ☐ Yes ☐ No
3. Skin color or rashes (circle one)? ..... ☐ Yes ☐ No
4. Overall development? ..... ☐ Yes ☐ No
5. Communication skills? ..... ☐ Yes ☐ No
6. Lack of interest in toilet training? ..... ☐ Yes ☐ No

Answer the following:

7. Is your child exposed to cigarette smoke? ..... ☐ Yes ☐ No
8. Were there any problems with immunizations in the past? ..... ☐ Yes ☐ No
9. Have you been sad, depressed or crying excessively? ..... ☐ Yes ☐ No
10. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ..... ☐ Yes ☐ No
11. Does your child eat non-food substances such as paint chips? ..... ☐ Yes ☐ No
12. Is your water source from a well? ..... ☐ Yes ☐ No

Does your child…

13. Speak in 2 to 3 (or more) word sentences? ..... ☐ Yes ☐ No
14. Become shy or anxious with strangers? ..... ☐ Yes ☐ No
15. Finger feed him/herself well ..... ☐ Yes ☐ No
16. Point to one or more body parts? ..... ☐ Yes ☐ No
17. Make animal sounds? ..... ☐ Yes ☐ No
18. Repeat words well? ..... ☐ Yes ☐ No
19. Try to feed him/herself with a spoon? ..... ☐ Yes ☐ No
20. Run well? ..... ☐ Yes ☐ No
21. Climb? ..... ☐ Yes ☐ No
22. Try to engage you with their eyes and gestures to communicate their needs? ..... ☐ Yes ☐ No
23. Jump with both feet off of the floor? ..... ☐ Yes ☐ No
22. Try to color with a crayon? ..... ☐ Yes ☐ No

Answer the following:

25. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
26. Does your child ride in a forward-facing infant car seat? ..... ☐ Yes ☐ No
27. Do you know infant CPR? ..... ☐ Yes ☐ No
28. September through March visits: Have all caregivers and family members living in the home been vaccinated for the flu this season? ..... ☐ Yes ☐ No
29. Are you giving your child a multivitamin with iron? ..... ☐ Yes ☐ No
30. Is your child eating all food groups: fruits, meats, and vegetables? ..... ☐ Yes ☐ No
31. Is your child off the bottle and on to a sipper cup with a hard plastic nipple? ..... ☐ Yes ☐ No
32. Are you brushing your child's teeth? ..... ☐ Yes ☐ No
33. How many ounces of milk does your child drink in one day? _____ What kind? _____
34. How many ounces of juice does your child drink in one day? _____
35. Have you switched to low fat or skim milk? ..... ☐ Yes ☐ No

24 Month (2 year) Questionnaire

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? ..... ☐ Yes ☐ No
3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ..... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ..... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? ..... ☐ Yes ☐ No

Lead Screening:

Does your child…

1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) ..... ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? ..... ☐ Yes ☐ No
3. Have a sibling or playmate who now has or did have lead poisoning? ..... ☐ Yes ☐ No
4. Is your child a refugee from another country? ..... ☐ Yes ☐ No
5. Does your child have their health insurance provided by Medicaid or INtotal Health? ☐ Yes ☐ No

Name and Ages of Brothers_____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ..... ☐ Yes ☐ No

_____

_____

_____

_____

_____

M CHAT

www.m-chat.org

Child's Name _____ Date _____

Date of Birth _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	YES	NO
2. Have you ever wondered if your child might be deaf?	YES	NO
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	YES	NO
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	YES	NO
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	YES	NO
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	YES	NO
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	YES	NO
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	YES	NO
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	YES	NO
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	YES	NO
11. When you smile at your child, does he or she smile back at you?	YES	NO
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	YES	NO
13. Does your child walk?	YES	NO
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	YES	NO
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	YES	NO
16. If you turn your head to look at something, does your child look around to see what you are looking at?	YES	NO
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	YES	NO
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	YES	NO
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	YES	NO
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	YES	NO