

## 2 years

Please check all the boxes that apply

### Feeding:

- Breast feeding
  - Formula feeding
  - Early introduction of solid baby food
  - Spitting up after feeding
  - Supplemental feeding after breast
  - Pumping and bottle
- Feeding

### Formula:

- whole milk
- 2% milk
- 1% milk
- Similac
- Enfamil
- Nestle Brand
- Gerber Good Start
- Other: \_\_\_\_\_

### Bottle Feeding Volume:

- Less than 20 oz. a day
- More than 20 oz. a day

### Feeding Frequency:

- Every 2 hours
- Every 3 hours
- Every 4 hours
- Every 5 or more hours

### Using Cup:

- uses cup
- uses bottle only
- uses both bottle and cup
- phasing out of bottle

### Juice:

- no juice
- drinks juice
- 4 oz/day
- 6 oz/day
- 8 oz/day
- 10 oz/day

### Solids:

- all 4 food groups
- picky eater
- good appetite
- cereal
- vegetables
- fruits
- meats
- no reactions
- reactions

### Elimination Stool:

- regular
- irregular
- soft BM
- Hard BM
- Constipation
- Diarrhea

### Elimination Urine:

- Urinating normal
- Trouble urinating

### Sleep/Position:

- through night
- wakes to feed
- wakes once
- wakes twice
- wakes >3 times
- Parent's room
- Infant's room

**Temperament:**

- Happy
- Fussy
- Easy
- Demanding
- Fussy but consolable

**Gross Motor Assessment:**

- walks up steps
- throws overhand
- kicks a ball
- runs well
- jumps
- balances on 1 foot for 1 second

**Fine Motor Assessment:**

- removes clothing
- stacks 4-6 objects
- able to draw lines and circles
- brushes teeth with help
- able to use a spoon well

**Communication:**

- combines words
- able to follow 2 part commands
- able to speak 20-50 words
- able to name 6 body parts
- understands cold-tired- hungry
- able to give first and last name

**Social:**

- pretend play
- parallel play
- helps with simple tasks
- puts clothes on
- wash/dry hands
- brush teeth

**M-CHAT**

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (for example, you've seen it once or twice), please answer as if the child does not do it.

	Yes	No
1. Does your child enjoy being swung, bounced on your knee, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child take an interest in other children?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child like climbing on things, such as up stairs?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child enjoy playing peek-a-boo / hide-and-seek?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child ever pretend, for example, to talk on the phone or take care of doll or pretend other things?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child ever use his/her index finger to point, to ask for something?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child ever use his/her index finger to point, to indicate interest in something?	<input type="checkbox"/>	<input type="checkbox"/>
8. Can your child play properly with small toys (i.e. cars or bricks) without just mouthing, fiddling, or dropping them?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child ever bring objects over to you (parent) to show you something?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child look you in the eye for more than a second or two?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child ever seem oversensitive to noise? (i.e. plugging his/her ears?)	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child smile in response to your face or your smile?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your child imitate you? (i.e., if you make a face will you child imitate it?)	<input type="checkbox"/>	<input type="checkbox"/>
14. Does your child respond to his/her name when you call?	<input type="checkbox"/>	<input type="checkbox"/>
15. If you point at a toy across the room, does your child look at it?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your child walk?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does your child look at things you are looking at?	<input type="checkbox"/>	<input type="checkbox"/>
18. Does your child make unusual finger movements near his/her face?	<input type="checkbox"/>	<input type="checkbox"/>
19. Does your child try to attract your attention to his/her own activity?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever wondered if your child is deaf?	<input type="checkbox"/>	<input type="checkbox"/>
21. Does your child understand what people say?	<input type="checkbox"/>	<input type="checkbox"/>
22. Does your child sometimes stare at nothing or wander with no purpose?	<input type="checkbox"/>	<input type="checkbox"/>
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever filled out this form before?

Yes No

How easy was it to fill out this form (Please circle one):

Very Easy Easy Somewhat Easy Not Easy at All

PEDIATRIC ASSOCIATES OF WESTERN CT, PC

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_