DAKOTA PEDIATRIC CLINIC

Health Supervision: 15-18 Months

Patient Name:_________________________________ **Date:** ________________________

To provide good preventative health care for your child, we would like to you answer these questions. It will help us focus on areas of possible concern. Your responses will be respected and kept confidential. Please feel free to add information or comments.

1. What questions or concerns do you have today?

2. Have there been any unexpected stresses, or family changes since your last visit?
   List:

3. Do you use a safety seat in the backseat every time your child rides in a car? Y N

4. Has your child had any injuries since the last visit? Y N

5. Do you have concerns about your child=s behavior? Y N

6. Do you have questions about discipline? Y N

7. Have you ever been in a relationship where you were hurt, threatened, or treated badly? Y N

8. Does anyone that cares for your child smoke? Y N
   Who?

9. Do you have concerns about your child's speech? Y N

10. What does your child eat?

Fruit	Y	N	Dairy	Y	N
Vegetables	Y	N	Milk	Y	N
Meat	Y	N	How many oz's each day?________		
Cereal/grains	Y	N	Juice	Y	N
			How many oz's each day?________		

OVER

11. Do you have any concerns about your child's use of his arms, hands, or legs?	Y	N
12. Do you brush your child's teeth?	Y	N
Do you use toothpaste?	Y	N
13. Does your child feed himself/herself?	Y	N
14. Does he/she drink from a cup?	Y	N
15. Does he/she drink from a bottle?	Y	N
16. Does he/she use a spoon?	Y	N
17. Do you know first aid for burns?	Y	N
18. Have you noticed any reactions to any foods, medications, environmental allergies?	Y	N
If so, describe:		
19. Do you have any concerns about your child's vision or hearing?	Y	N

Additional comments or questions:

Parent/Guardian:____