KAISER PERMANENTE®

Well-Visit Questionnaire
Children Age 2 Years

Your child is 2 years old!

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
☐ Well Visit ☐ Allergies ☐ Cold/flu ☐ Constipation ☐ Cough ☐ Development ☐ Earache ☐ Fever ☐ Growth/nutrition ☐ Injury ☐ Rash ☐ Red eyes ☐ Sore throat ☐ Speech ☐ Temper ☐ Vaccines ☐ Vomiting ☐ Other (please explain):_____ **Briefly describe your concern:**_____	
Health Changes	
Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____	☐ Yes ☐ No
Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____	☐ Yes ☐ No
Nutrition, Feeding and Supplements – Tell us about what your child eats.	
My child eats a variety of fruits and/or vegetables over the course of a week:	☐ Yes ☐ No
My child has a daily source of iron in their diet, like meat or beans:	☐ Yes ☐ No
Please list any other vitamins, supplements, or over-the-counter medicines you give your child: _____	
Dental Health	
Has your child seen a dentist?	☐ Yes ☐ No
Child Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.	
My child:	
Knows at least 50 words, including 5 body parts:	☐ Yes ☐ No
Uses 2-word phrases:	☐ Yes ☐ No
Follows 2-step directions:	☐ Yes ☐ No
Talks so a stranger would understand at least half of their speech:	☐ Yes ☐ No
Uses 1 foot per step when going up stairs or climbing a ladder:	☐ Yes ☐ No
Jumps with two feet:	☐ Yes ☐ No
Kicks a ball:	☐ Yes ☐ No
Uses a utensil to feed themselves:	☐ Yes ☐ No
Turns lids, pages, and doorknobs:	☐ Yes ☐ No
Can draw a line:	☐ Yes ☐ No
Enjoys playing around other children:	☐ Yes ☐ No
Enjoys showing me things	☐ Yes ☐ No
Looks at things if I point at them:	☐ Yes ☐ No
Plays pretend and imitates:	☐ Yes ☐ No

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Is easy to console, and not aggressive or anxious:	☐ Yes ☐ No
Uses screens (TV/phone/tablet/computer) for 1 hour per day or less:	☐ Yes ☐ No
Only views screen content chosen by me or another adult:	☐ Yes ☐ No
Do you read to your child daily?	☐ Yes ☐ No
Does your family enjoy physical activities outdoors with your child?	☐ Yes ☐ No
Safety	
My child uses a car seat with a 5-point harness:	☐ Yes ☐ No
We have gates across stairs and safety guards on windows:	☐ Yes ☐ No
We have cleaning supplies, medicines, and matches locked away:	☐ Yes ☐ No
My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets):	☐ Yes ☐ No
The buildings where my child lives or regularly visits were built after 1978 or, if built before 1978, have not been renovated in the past 6 months and do not have peeling paint:	☐ Yes ☐ No
Our furniture is bolted to the wall to prevent tipping:	☐ Yes ☐ No
My home has smoke detectors:	☐ Yes ☐ No
There are guns in our home or in other homes where my child visits:	☐ Yes ☐ No ☐ I don't know
If Yes, are all guns stored unloaded and locked away, with ammunition locked away separately?	☐ Yes ☐ No ☐ I don't know
Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	☐ Yes ☐ No
What is your plan for childcare? ☐ Home with parent ☐ Family member ☐ Nanny or Sitter ☐ Childcare center	
Do you need assistance finding affordable and safe childcare?	☐ Yes ☐ No
Is there anyone who lives in your home or cares for your child who:	
- Smokes or vapes tobacco or marijuana:	☐ Yes ☐ No
- Uses prescription pain medication:	☐ Yes ☐ No
- Uses other drugs:	☐ Yes ☐ No
- Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	☐ Yes ☐ No
Within the past 12 months, have you:	
- Run out of food or been worried your food would run out before there was money to buy more?	☐ Yes ☐ No
- Worried about housing or had to move?	☐ Yes ☐ No
- Had difficulty getting other supplies and services you need to care for your child? Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	☐ Yes ☐ No

NOT TO BE FILED IN THE MEDICAL RECORD

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