10 mo. Child Exam Questionnaire

Reception No.（number card）

Full name : **School District : (　　　　　)**

Date of Birth : ___year ___month ___day

Please write any concerns/questions you may have regarding your child's health below.

1. Does your child play by pulling their feet up to their face?　(yes / no)
2. When could your child sit without using his/her hands?　(　　　mo.)
3. When did your child start crawling on their belly?　(　　　mo.) on hands and knees? (　　　mo.)
4. When could your child hold onto something and stand on their own?　(　　　mo.)
5. When could they walk while holding onto something?　(　　　mo.)
6. Can your child go from lying face-down to sitting, and from sitting to face-down?（yes / no)
7. Does your child use a baby-walker?　(yes / no)
8. Does your child turn their head towards small noises?（ex. ripping a paper bag)　(yes / no)
9. What sounds/words has your child been saying lately?

　〔　　　　　　　　　　　　〕

10. From when would your child look in the direction you point to while at the same eye-level?
    (　　　mo.)
11. When did your child begin to imitate your mannerisms/gestures?　(　　　mo.)
    What do they imitate〔ex: clapping　　　　　　　　　〕
12. Is your child happy when they see small children or siblings?（ yes / no ）
13. When did your child begin to stare at/be shy of strangers?　(　　　mo.)
14. Does your child chase after you and cry?　(　yes〔　　mo.〕/ no　)
15. What types of play does your child enjoy most?

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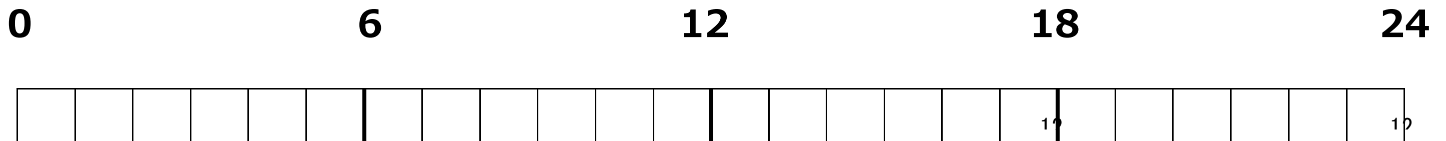
16. Will your child open their mouth for food if you open your mouth wide?（ yes / no ）
17. Do you have any child-rearing difficulties? (crying often, won't eat, trouble sleeping, etc.)
    (no / yes　)
18. Do you often feel irritated or frustrated with raising your child?
    (no / can't say either / yes)
19. Do you have any concerns about yourself?　(　no / yes　)

Cont. on back

〔 health or family concerns, etc. 〕

20. Has your child ever had any serious illnesses or gone to a hospital regularly? (no / yes)
21. Convulsions? (no / yes) (fever at that time ℃)
22. Do you have an allergy concerns? (no/yes)
    Is your child currently undergoing treatment? (no/yes 〔dermatitis/food/other 〕)
23. bowel movement (___times/___day(s))
24. baby food (___times per day)
    Approximate amount and contents of food
    - Staple food 〔 〕 main dish・other 〔 〕
    - Milk formula (cc times) breast-feeding (times) tea (cc)
    - other (cc)
    - How do your prepare potatoes/similar foods? (mashed・ small pieces ・larger pieces)
    - Do you let your child eat with their hands? (yes/ only snacks/ no)
    - Are you practicing using straws and cups? (yes / no)
    - Does your child have a good appetite? (yes / no)
    - Do you eat dinner as a family? (yes / no)
25. When did teeth first start coming in? (mo.)
26. Does your child use a pacifier? (no / yes)
27. Sleep rhythm, (Please fill in the hours that your child sleeps)



28. When do you most enjoy raising your child?

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