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?

（　　）

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. 〕

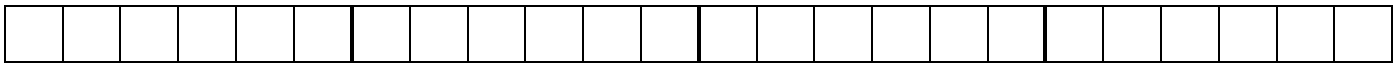
20. Has your child ever had any serious illnesses or gone to a hospital regularly? (no / yes)
21. Convulsions? (no / yes) (fever at that time ℃)
22. Do you have an allergy concerns? (no/yes)

    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)

0 6 12 18 24



28. When do you most enjoy raising your child?

〔 〕