3 yr 6 mo. Child ExamQuestionnaire

Reception No.（number card）

Full name: **School district : (　　)**

Date of birth: ____year ___mo. ___day

※Please fill out these questions along with the “Child’s Hearing Questionnaire” in the front of your baby booklet and the “Whisper Test” sheet.

Please write any concerns/questions you may have about your child’s health below.

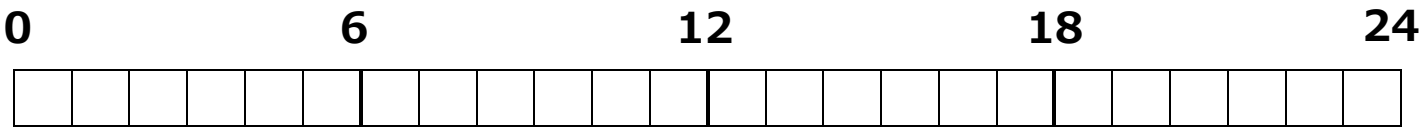
1. Can your child climb the stairs with alternating legs by themselves? （ yes / no ）
2. Have you ever been concerned about the way your child walks or runs? （ no / yes ）
3. Can hold scissors in one hand and use them properly （ yes / no ）
4. Can say their own name and surname. （ yes / no ）
5. Can your child answer questions connecting 3 or more words? (ex: “I played outside on the slide”)（ yes / no ）
   Please write some examples.
   Ex. Questions from adult「　　」
   Child’s answer「　　」
6. Do you have any concerns about your child’s pronunciation?（ no / yes　　）
7. Does your child play house/pretend with friends?（ yes / sometimes / not often ）
8. Circle all of the following that apply to your child.
   throws tantrums / won’t calm down / unusual habits / plays the same thing alone all the time / cries at night / extremely afraid of some things / overly fussy / won’t play with friends
9. Do you often feel irritated or frustrated with raising your child? （ no / neither / yes ）
10. Do you have any concerns about yourself? （ no / yes ）
    〔 health, family, etc.　　〕
11. Can your child dress/undress by themselves?（ yes / no ）　　）
12. Daytime bathroom habits（ uses toilet / toilet training / does not let you know ）
13. Does your child perform any household tasks as a part of the family?（ yes / no ）
    〔example:　　〕

Cont. on back

14. Can your child eat by him/herself? （ yes / no ）（ chopsticks / spoon / hands ）
15. Do you have any concerns about your child's eyes/ears?（ no / yes ）
16. Has your child ever had feverless seizures or several febrile seizures? （ no / yes ）
17. Please circle the meals your child eats. （ breakfast / lunch / dinner ）
18. Do you eat dinner as a family? （ yes / no ）
19. Does your child have opportunities to play with friends? （ yes / no ）
20. How does your child usually play?（ childcare center/kindergarten ）

（ At home:
Outside the home: ）

21. How often does your child walk/play outside? （____times/week）
22. Sleep rhythm（please fill in the hours your child sleeps）



23. When do you most enjoy raising your child?

（ ）

Teeth and mouth care

- Does your child brush their teeth? no / yes（parent finishes? yes / no ）
  （ sometimes / every morning / every night / after every meal ）
- Does your child suck their thumb/pacifier?（ no / yes ）
- Snacks regularly（___times/day） / irregularly
  〔contents 〕
- Mainly drinking (milk ___cc) other（ _____cc)（ _____cc)
- Does he/she have any extreme likes/dislikes? （ no / yes ）
- Does your child chew properly when eating? （ yes / no ）