

2 Year, 6 Months Child Health Examination Questionnaire

Furigana			Date of Birth:	Family Makeup: Family members living with the child (excluding the child themselves)				
Child's Name			[Year] ____ [Month] ____ [Day] ____ (Child Number: ____)	Relation	Age	Relation	Age	
Address	Otsu City		(School District: _____)					
	Do you have plans to move in the near future? (No • Yes)							
	TEL		TEL					
	Contact①	Father • Mother • Grandfather • Grandmother • Other (_____)	Contact②	Father • Mother • Grandfather • Grandmother • Other (_____)				
Attending Daycare/Preschool: Yes (Name of Childcare Facility: _____) / No				Birth Height: _____ cm		Birth Weight: _____ g		

◆Please refer to your Maternal and Child Health Handbook (Boshi Techo), circle the applicable items, and fill in the parentheses when necessary.

A. Development	1. Can they jump with both feet together?		1 Yes	2 No										
	2. Do they draw circles and name them (for example, saying "This is a car/vroom-vroom")?		1 Yes	2 No										
	3. Development History	•When you show them a picture book and ask, "Which one is the train?" or "Where is the bird?", do they point to the correct one?	(____ years ____ months old)											
		•Do they prefer the larger item when offered a choice, or do they use words like "big" and "small"?	(____ years ____ months old)											
		•Do they use phrases using 2 or more words, such as "Go outside" or "Doggie sleeping"?	(____ years ____ months old)											
	4. Please write down some examples of words or phrases your child has used recently.		[_____]											
	5. Has their interest in speaking/language grown to the point where they frequently ask, "What's this?"		1 Yes	2 No										
6. Do they enjoy "make-believe" or "pretend" play with others (for example, pretending a doll is a baby and hugging it)?		1 Yes	2 No											
7. Do you have any concerns regarding their behavior?		1 No	2 Yes											
B. Medical History	8. Has your child ever had a serious illness, or are they currently seeing a doctor for any ongoing conditions?		1 No	2 Yes (_____)										
	9. Does your child have a regular family dentist?		1 Yes	2 No 3 Not sure										
C. Lifestyle Habits	10. Does your child suck their thumb or use a pacifier?		1 No	2 Yes										
	11. Does your child have a set time for snacks?		1 Yes	2 No										
	12. Does your child frequently have sugary drinks (such as juice)?		1 No	2 Yes										
	13. Do you (parent/guardian) perform follow-up brushing of their teeth every day?		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>1 Parent/guardian performs follow-up brushing (Parent brushes after the child)</td> <td>1</td> </tr> <tr> <td>2 Only parent/guardian brushes (Child does not brush themselves)</td> <td>2</td> </tr> <tr> <td>3 Child brushes alone</td> <td>3</td> </tr> <tr> <td>4 Neither child nor parent brushes the child's teeth</td> <td>4</td> </tr> </table>			1 Parent/guardian performs follow-up brushing (Parent brushes after the child)	1	2 Only parent/guardian brushes (Child does not brush themselves)	2	3 Child brushes alone	3	4 Neither child nor parent brushes the child's teeth	4	
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	3 Child brushes alone	3												
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	14. How much time does your child spend watching TV or using a tablet/smartphone per day?		About: ____ hours											
15. Does your child have opportunities to play with friends?		1 Yes	2 No											
16. Does your child show interest in playing with other children?		1 Yes	2 No											
17. What kind of activities or games does your child usually play?		At home: (_____) Outside: (_____)												
18. Daily routine (Please fill in/color the blocks for the times your child is asleep)		<table style="width: 100%; text-align: center;"> <tr> <td>0</td><td>6</td><td>12</td><td>18</td><td>24</td> </tr> <tr> <td>□</td><td>□</td><td>□</td><td>□</td><td>□</td> </tr> </table>			0	6	12	18	24	□	□	□	□	□
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D. Diet / Eating	19. Please circle the meals your child is currently eating.		Breakfast • Lunch • Dinner											
	20. Does your child feed themselves using utensils (spoon, fork, chopsticks, etc.)?		1 Yes	2 No										
	21. Does your child eat meals together with the family?		1 Yes	2 No										
E. Childcare	22. When do you feel the most joy or fulfillment in raising your child?		[_____]											
	23. Do you find it hard to go out with your child?		1 No	2 Yes										
	24. Do you often feel frustrated or overwhelmed by childcare?		1 No	2 Not sure / neutral										
	25. Please use this space for any other concerns or topics you would like to discuss.		[_____]											

Please use this space if there are any other matters you would like to discuss regarding yourself as a parent/guardian (such as your own health, family relationships, etc.).