1 yr. 9 mos. Child Exam Questionnaire

Reception No.（number card）

Full name : **School district : (　　)**

Date of birth : ____year ____mo. ____day

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

1. From when could your child walk on their own?（　　yrs.　　mos.　）
2. Do you have any concerns about how your child walks?（ no / yes ）
3. If you draw a circle, will your child copy you and draw the same thing?（ yes / no ）
4. Does your child respond when you ask him/her to bring something?（ yes / no ）
5. At what age did your child start saying small words with meaning?　（　　yrs.　　mos.）
6. When did your child start pointing at things that he/she wants?　（　　yrs.　　mos.）
7. When did your child start to point at things outside to draw your attention to them?（ yrs. mos.）
8. At what age could your child correctly point out things in books such as trains, birds, etc.?
   （　　yrs.　　mos.　）
9. Please write several words that your child has been saying lately.
   （　　）
10. Will your child turn around at the sound of their name being whispered?　（ yes / no ）
11. If you try to help your child, will they say things like "no" or "more"?
    yes（　　yrs.　　mos.）/ no)
12. How will your child ask you for something they want?
    a．pull your hand　b．point　c．use words
    d．get it for themselves without telling an adult　e．do nothing
13. Will your child ask for an adult's help when they need it?（ yes / no ）
14. Circle if you have any of the following concerns.（circle all that apply）
    won't make eye contact / won't come when called / plays alone / too independent / overactive / won't sit still to eat / doesn't sleep well / cries at night / too quiet / doesn't imitate things they used to
15. Is it a burden to go out with your child?　（ no / yes ）
16. Do you often feel irritated or frustrated with raising your child?
    （ no / yes and no / yes ）

Cont. on back

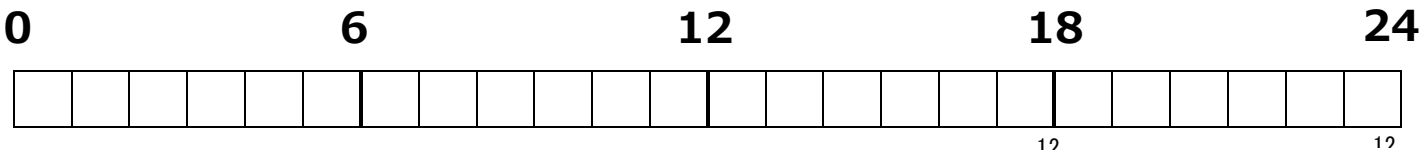
17. Do you have any concerns about yourself? (no / yes)

(health, family, etc.)

18. Do you have any concerns about your child's eyes or ears? (no / yes)
19. Has your child ever had feverless seizures or had several febrile seizures? (no / yes)
20. Does your child take off their clothes by themselves? (yes / no)
21. Does your child tell you after they've used their diaper? (yes / no)
22. Does your child want to do the same things as you? (vacuuming, using keys, etc.)
(yes / no)
23. Please circle the meals your child eats. (breakfast ・ lunch ・ dinner)
24. Does your child eat/try to eat by themselves? (yes ・ no) (w/ spoon / w/ hands)
25. Do you eat dinner as a family? (yes ・ no)
26. Does your child get regular opportunities to play with other children? (yes / no)
27. How does your child usually play?

(At home:
Outside:)

28. How often does your child walk/play outside? (___times per week)
29. Sleep rhythm (please fill in the hours your child sleeps)



30. 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)
- Do you use a bottle? no / yes contents (c c) used when ( )
- Are you breastfeeding? 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)