2 yrs. 6 mo. 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. Can your child jump with their legs together? (yes / no)
2. Does your child draw a circle or shape and call it something? (car, person, etc.) (yes / no)
3. Can your child eat on their own with a spoon or fork? (yes / no)
4. At what age could your child name things in a picture book? (trains, birds, etc.) (yrs. mos.)
5. At what age did your child begin putting two or more words together? ("go outside", "dog is sleeping" etc. (yrs. mos.)

   Please write several words that your child has been saying lately.

   〔　　〕

6. Do you have any concerns about your child's language development? (no / yes)
7. Is your child interested in new words and asking you what things are? (yes / no)
8. Does your child enjoy playing make believe with dolls as if they were real? (yes / no)
9. Can your child differentiate between large and small, asking for the larger option? (yes / no)
10. Does your child insist on doing things by his/herself? (yes / no)
11. Will your child pick out his/her own clothes/shoes if asked? (yes / no)
12. Will your child agreeably move on when told "just one more time"? (yes / no)
13. Circle all of the following that apply to you.

    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
14. Is it a burden to go out with your child? (no / yes)
15. Do you often feel irritated or frustrated with raising your child? (no / neither / yes)
16. Do you have any concerns about yourself? (no / yes)

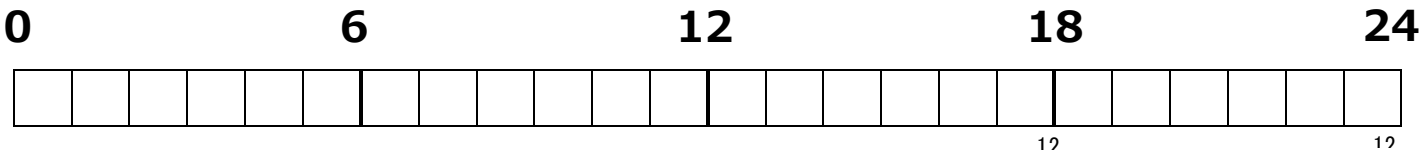
    〔 health, family, etc. 〕

Cont. on back

17. Do you have any concerns about your child's eyes/ears? (no / yes)
18. Has your child ever had feverless seizures or several febrile seizures? (no / yes)
19. Has your child ever had any serious illnesses or injuries? (no / yes)
20. Which does your child use? (underwear / diaper)
21. Does your child see what you are doing and try to help? (yes / no)
22. Please circle the meals your child eats. (breakfast / lunch / dinner)
23. Do you eat dinner as a family? (yes / no)
24. Does your child have opportunities to play with friends? (yes / no)
25. Is your child interested in playing with friends? (yes / no)
26. How does your child usually play? (childcare center/kindergarten)

(At home:
Outside the home:)

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



29. 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 your breastfeeding? no / yes
- Snacks regularly (___times/day) / irregular
  〔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)