

American Academy of Pediatrics



## BRIGHT FUTURES PREVISIT QUESTIONNAIRE

# 2½ YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. **Child Development screening is also part of this visit.** Thank you.

### WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today?  No  Yes, describe:

### TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs?  No  Yes, describe:

Have there been major changes lately in your child's or family's life?  No  Yes, describe:

Have any of your child's relatives developed new medical problems since your last visit?  No  Yes  Unsure If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  No  Yes  Unsure

### YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior?  No  Yes, describe:

**Check off each of the tasks that your child is able to do.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Urinate in a potty or toilet.             | <input type="checkbox"/> Use pronouns, such as "me," "his," and "our," correctly.                  | <input type="checkbox"/> Run well without falling.                              |
| <input type="checkbox"/> Poke food with a fork.                    | <input type="checkbox"/> Explain the reasons for things, such as needing a sweater when it's cold. | <input type="checkbox"/> Copy a vertical line.                                  |
| <input type="checkbox"/> Wash and dry hands.                       | <input type="checkbox"/> Name at least one color.  | <input type="checkbox"/> Grasp a crayon with thumb and fingers instead of fist. |
| <input type="checkbox"/> Play pretend with toys or dolls.          | <input type="checkbox"/> Walk up steps, using one foot, then the other.                            | <input type="checkbox"/> Catch large balls.                                     |
| <input type="checkbox"/> Ask you to watch by saying, "Look at me!" |  |   |

## 2½ YEAR VISIT

### RISK ASSESSMENT

<b>Anemia</b>	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Hearing</b>	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Oral health</b>	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

### ANTICIPATORY GUIDANCE

#### How are things going for you, your child, and your family?

#### FAMILY ROUTINES

Does your family eat meals together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a regular bedtime routine for your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do you encourage family exercise, such as walking, swimming, dancing, or bicycling?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family go to museums, zoos, and other educational places together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you and your partner participate in social activities? Do you do things with friends, away from the family?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in your family follow the same routines and set the same limits for your child?	<input type="radio"/> Yes	<input type="radio"/> No

#### LEARNING TO TALK AND COMMUNICATE

Do you read to your child every day?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use simple words when asking your child a question and give plenty of time for her to respond?	<input type="radio"/> Yes	<input type="radio"/> No
Do you carefully listen to your child and, if necessary, offer the right words to help him make sure he is understood?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child become frustrated when others cannot understand what he says?	<input type="radio"/> No	<input type="radio"/> Yes

#### GETTING ALONG WITH OTHERS

Does your child play with other children?	<input type="radio"/> Yes	<input type="radio"/> No
Do you allow your child to make choices such as what clothes to wear, what to eat, and what books to read?	<input type="radio"/> Yes	<input type="radio"/> No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
If your child uses media, do you monitor the shows your child watches or activity she does?	<input type="radio"/> Yes	<input type="radio"/> No
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No

#### GETTING READY FOR PRESCHOOL

Do you have plans for child care or preschool in the next year?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child a part of a regular playgroup?	<input type="radio"/> Yes	<input type="radio"/> No
Do you read books to your child about getting ready for school?	<input type="radio"/> Yes	<input type="radio"/> No
Are you encouraging toilet training?	<input type="radio"/> Yes	<input type="radio"/> No
Do you praise your child when she tries to use the potty?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 2½ YEAR VISIT

### SAFETY

Car and Home Safety		
Is your child fastened securely in a car safety seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a working smoke detector on every level of your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you test the batteries once a month?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have an emergency escape plan in case of a fire?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep matches out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from the stove, grills, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No
Outdoor Safety		
When your child plays outside, do you make sure that he stays within fences and gates?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?	<input type="radio"/> Yes	<input type="radio"/> No
Have you taught your child to be careful around dogs, especially if they are eating or you don't know them?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a swimming pool, pond, or lake near your home?	<input type="radio"/> No	<input type="radio"/> Yes
Do you always put sunscreen on your child when she plays outside?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*

For more information, go to <https://brightfutures.aap.org>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit, 2nd Edition*.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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Child's Name

Date of Birth

Today's Date

### M-CHAT Autism Screen

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (i.e., you've seen it once or twice), please answer as if the child does **not** do it.

Questions	Yes	No
1. Does your child enjoy being swung, bounced on your knee, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
2. * Does your child take an interest in other children?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child like climbing on things, such as up stairs?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child ever use his/her index finger to point, to ask for something?	<input type="checkbox"/>	<input type="checkbox"/>
7. * Does your child every use his/her index finger to point, to indicate interest in something?	<input type="checkbox"/>	<input type="checkbox"/>
8. Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them?	<input type="checkbox"/>	<input type="checkbox"/>
9. * Does your child ever bring objects over to you (parent) to show you something?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child look you in the eye for more than a second or two?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child smile in response to your face or your smile?	<input type="checkbox"/>	<input type="checkbox"/>
13. * Does your child imitate you? (e.g., if you make a face, will your child imitate it?)	<input type="checkbox"/>	<input type="checkbox"/>
14. * Does your child respond to his/her name when you call?	<input type="checkbox"/>	<input type="checkbox"/>
15. * If you point at a toy across the room, does your child look at it?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your child walk?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does your child look at things you are looking at?	<input type="checkbox"/>	<input type="checkbox"/>
18. Does your child make unusual finger movements near his/her face?	<input type="checkbox"/>	<input type="checkbox"/>
19. Does your child try to attract your attention to his/her own activity?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever wondered if your child is deaf?	<input type="checkbox"/>	<input type="checkbox"/>
21. Does your child understand what people say?	<input type="checkbox"/>	<input type="checkbox"/>
22. Does your child sometimes stare at nothing or wander with no purpose?	<input type="checkbox"/>	<input type="checkbox"/>
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	<input type="checkbox"/>	<input type="checkbox"/>

***Two or more of the asterisked (\*) items, or three of any items require more evaluation or referral.***



PATIENT

Last Name	First Name	MI	Date of Birth
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PARENT/GUARDIAN

Last Name	First Name	MI
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**Patient Eligibility Screening Record**

**Vaccines for Children Program**

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider’s office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits as long as the child’s eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of \$21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

<b>Check only ONE (1) box. My child...</b>		
(A) is enrolled in Medicaid (PeachState, WellCare, AmeriGroup, CareSource or SSI Medicaid).	<input type="radio"/>	OR
(B) is American Indian or Alaskan Native.	<input type="radio"/>	OR
(C) does not have health insurance.	<input type="radio"/>	OR
(D) has health insurance that does not pay for vaccines.	<input type="radio"/>	OR
(E) is enrolled in PeachCare (PeachCare will be listed as Managed Care Provider).	<input type="radio"/>	OR
(F) has health insurance that pays for vaccines.	<input type="radio"/>	

Parent/Guardian Name (print)

Signature

Date

# PEDS RESPONSE FORM

Child's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_

Child's Birthday \_\_\_\_\_ Child's Age \_\_\_\_\_ Today's Date \_\_\_\_\_

1. Please list any concerns about your child's learning, development, and behaviour.

2. Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

5. Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

6. Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

7. Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

9. Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

10. Please list any other concerns.

# PEDS SCORE FORM – AUTHORISED AUSTRALIAN VERSION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date(s) of scoring: \_\_\_\_\_

Find appropriate column for the child's age. Place a tick in the appropriate box to show each concern on the PEDS Response Form. See Brief Scoring Guide for details on categorising concerns. Shaded boxes are significant predictors of difficulties. Non-shaded boxes are non significant predictors.

Child's Age:	0-3 mos	4-5 mos	6-11 mos	12-14 mos	15-17 mos	18-23 mos	24-35 mos	36-47 mos	48-53 mos	54-71 mos	72-83 mos	84-96 mos
Global/Cognitive	<input type="checkbox"/>											
Expressive Language and Articulation	<input type="checkbox"/>											
Receptive Language	<input type="checkbox"/>											
Fine Motor	<input type="checkbox"/>											
Gross Motor	<input type="checkbox"/>											
Behaviour	<input type="checkbox"/>											
Social-emotional	<input type="checkbox"/>											
Self-help	<input type="checkbox"/>											
School	<input type="checkbox"/>											
Other	<input type="checkbox"/>											

Count the number of ticks in the small shaded boxes and place the total in the large shaded box below.

<input type="checkbox"/>											
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If the number shown in the large shaded box is 2 or more, follow **Path A** on PEDS Interpretation Form. If the number shown is exactly 1, follow **Path B**. If the number shown is 0, count the number of ticks in the small unshaded boxes and place the total in the large unshaded box below.

<input type="checkbox"/>											
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

If the number shown in the large unshaded box is 1 or more, follow **Path C**. If the number 0 is shown, consider **Path D** if relevant. Otherwise, follow **Path E**.

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Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Specific Decisions

### PEDS INTERPRETATION FORM

0-3 mos. \_\_\_\_\_

4-5 mos. \_\_\_\_\_

6-11 mos. \_\_\_\_\_

12-14 mos. \_\_\_\_\_

15-17 mos. \_\_\_\_\_

18-23 mos. \_\_\_\_\_

24-35 mos. \_\_\_\_\_

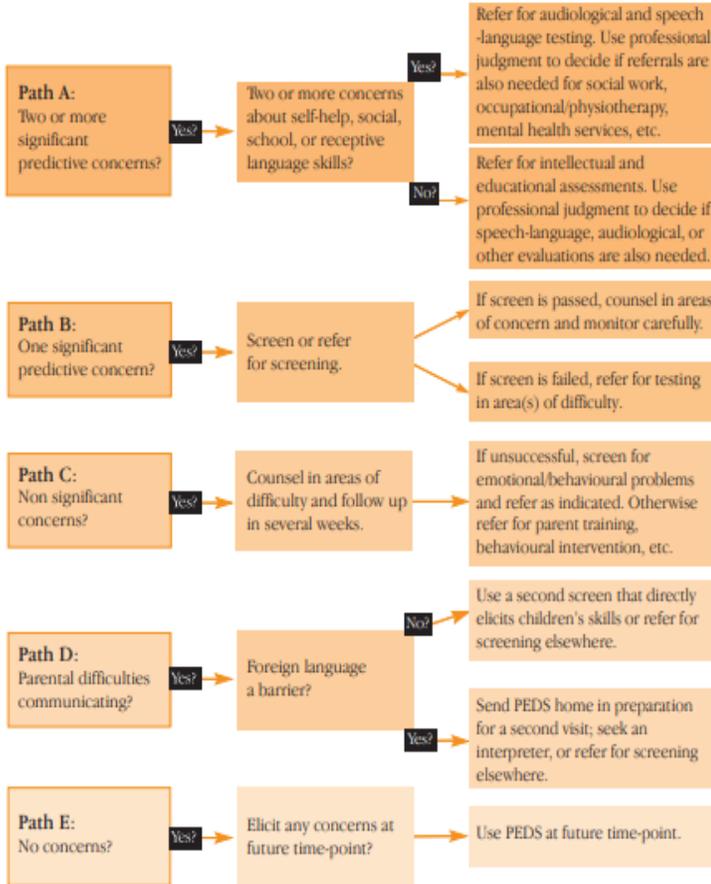
36-47 mos. \_\_\_\_\_

48-53 mos. \_\_\_\_\_

54-71 mos. \_\_\_\_\_

72-83 mos. \_\_\_\_\_

84-96 mos. \_\_\_\_\_



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