6 Month to 3 Year Visit Questionnaire

Patient's Last Name: ___________________ First Name: ________________ Birthdate:____________ Today's Date:_____________

Question	CIRCLE		*(If yes, explain below)
General:			
Do you have any specific concerns for today's visit?	No	Yes*	
Is your child taking any prescription medications?	No	Yes*	
Are your child's vaccines covered by your insurance plan?	No	Yes	
Is your child seeing a specialist for any ongoing medical problem(s)?	No	Yes*	
Has your child been seen in a hospital ER or treatment center since the last visit here?	No	Yes*	
Does your child have any ongoing medical problems or diagnosis? (If yes, please list on bottom.)	No	Yes*	
Family Medical:			
Do the parents have any significant medical issues that we should be aware of?	No	Yes*	
Have there been any other significant family medical issues recently?	No	Yes*	
Social:			
Are the biological parents married?	No	Yes	
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes*	
Are there any smokers in the household? (If yes, please indicate who)	No	Yes*	
Do you have any concerns regarding domestic abuse or child abuse in your household?	No	Yes*	
Symptom Review:			
Has your child had any fever (over 100.4), runny nose or significant cough in the last 3 days?	No	Yes*	
Do you have any concerns regarding your child's sleep habits?	No	Yes*	
Do you have any concerns regarding your child's behavior?	No	Yes*	
Do you notice problems with eye muscle alignment, drifting, crossing or laziness?	No	Yes*	
Does your child have ongoing eye redness or discharge?	No	Yes*	
Do you have any concerns regarding your child's hearing?	No	Yes*	
Is the child having any significant breathing problems that you are concerned about?	No	Yes*	
Has your child had episodes of vomiting recently?	No	Yes*	
Do you have any concerns regarding your child's stooling habits?	No	Yes*	
Do you have any concerns regarding the child's use of his/her legs or arms?	No	Yes*	
Do you have any concerns regarding your child's voiding/urinary habits?	No	Yes*	
Does your child have any unusual rashes that you are concerned about?	No	Yes*	

*Explain 'YES" Answers: ____

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Version 7-5-20

Patient Last Name: ____________________ Patient First Name: ____________________

Birthday: ______________ Today's Date: ______________

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

Question		
1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

Total Score: ____________________