

Patient Name _____

Date of Birth _____



Risk Assessment 2 1/2 Year

Has your child been to the dentist?	Yes	No	Comment
Plays pretend	Yes	No	Comment
Plays with other children, like tag	Yes	No	Comment
When talking, puts 3-4 words together	Yes	No	Comment
Other people can understand what child is saying half the time	Yes	No	Comment
Points to 6 body parts	Yes	No	Comment
Knows correct animal sounds (such as cat meows, dog barks)	Yes	No	Comment
Brushes teeth with help	Yes	No	Comment
Jumps up and down in place	Yes	No	Comment
Puts on clothes with help	Yes	No	Comment
Washes and dries hands without help	Yes	No	Comment
Concerns about how child speaks	No	Yes	Concerns
Concerns about how child hears	No	Yes	Concerns
Concerns about how child sees	No	Yes	Comment
Any concerns for crossing, drifting or lazy eyes	No	Yes	Comment

Anticipatory Guidance:

Parents and other caregivers set same limits for child	Yes	No	Comment
Encourages family exercise such as; walking, swimming, dancing, or bicycling	Yes	No	Comment
Has a regular bed time routine	Yes	No	Comment
Reads with child everyday	Yes	No	Comment
Has daily routines for eating, sleeping and playing	Yes	No	Comment
Has encouraged toilet training	Yes	No	Comment

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Is child part of a regular playgroup	Yes	No	Comment
Always uses car seat in back seat of car	Yes	No	Comment
Wears helmet when riding tricycle, motorized kid car, or in seat of adult bike	Yes	No	Comment
Do you put sunscreen on child before he/she goes outside	Yes	No	Comment
Have a gun in the home, or any home child spends time	No	Yes	Comment
Does anyone smoke around child	No	Yes	Comment