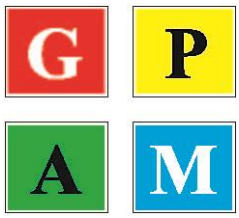
Patient Name_____
Date of Birth_____



Risk Assessment 2 ½ 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

Patient Name_____

Date of Birth_____

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

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

Child's Name: _____

Date of Birth: _____

Today's Date: _____

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

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