

## Patient intake for 2 YEAR OLD HEALTH SUPERVISION

\*Please either circle or fill in responses\*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_

Source of information for this visit: Mother Father Other: \_\_\_\_\_

Chief complaint/Appointment goal: \_\_\_\_\_

Is this visit related to an injury? YES NO

### Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: \_\_\_\_\_
- Preferred spoken language: \_\_\_\_\_
- Preferred written language: \_\_\_\_\_

#### Preferred mode of communication:

Verbal Sign language Written Assistive Communication Device

#### Preferred method of learning:

Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

#### Preferred method of communication:

No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.

If Yes – please explain \_\_\_\_\_

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: \_\_\_\_\_

◆ Do you suspect your child is in pain?  
**Staff- Evaluate pain with FLACC Scale\***

YES

NO

Has the patient been seen elsewhere since their last clinic visit with us?

YES

NO

If yes, explain: \_\_\_\_\_ ( ◆ Staff- Request Records\*)

### Review of Symptoms (Place an "X" in all categories that apply):

|                        |  |                          |  |                    |  |
|------------------------|--|--------------------------|--|--------------------|--|
| Poor weight gain       |  | Fever                    |  | Cough              |  |
| Hearing concerns       |  | Headache                 |  | Wheezing           |  |
| Vision concerns        |  | Sinus Congestion Present |  | Vomiting           |  |
| Difficulty Breathing   |  | Nasal Discharge          |  | Diarrhea           |  |
| Snoring                |  | Ear Pain                 |  | Abdominal Pain     |  |
| Change in bowel habits |  | Pulling on Ears          |  | Decreased Appetite |  |
| Sweating with feeds    |  | Ear Drainage             |  | Other:             |  |
| Rash                   |  | Sore Throat              |  |                    |  |

## Family Screening

|                                                                                                                       |     |    |
|-----------------------------------------------------------------------------------------------------------------------|-----|----|
| Are any members of the household currently <u>deployed or on extended duty outside of the immediate area?</u>         | YES | NO |
| Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid? | YES | NO |

## Nutrition

Number of substantial breakfasts (# of days per week): \_\_\_\_\_

Number of Sweetened Drinks per day? \_\_\_\_\_

Amount of Fruit servings per day? \_\_\_\_\_

Amount of Vegetable servings per day? \_\_\_\_\_

Number of Meals with Family per week? \_\_\_\_\_

## Tuberculosis (TB) Screen

Has a family member or contact had active tuberculosis? Yes. No.  
Has a family member had a positive tuberculin skin test? Yes. No.  
Was your child born in a high-risk country? Yes. No.  
Has your child traveled to a high risk country for more than one week? Yes. No.

## Oral Health Screening

Has your child had a dental cleaning/check-up in the past 6-12 months? Yes. No.  
Do you brush your child's teeth using fluoride toothpaste? Do Yes. No.  
you have any concerns about your child's oral health? Yes. No.

## Lead Screen

- What is your child's primary address? \_\_\_\_\_
- Has a sibling or playmate had lead poisoning? Yes. No. Don't Know.
- Does your child reside in or visit a house or childcare facility built before 1978 which has peeling or chipping paint or has been renovated or remodeled within the last 6 months? Yes. No. Don't Know.
- Does your child come in contact with an adult whose job or hobby involves lead exposure (firing range, metal work, mining, stained glass work, renovation/remodeling)? Yes. No. Don't Know.
- Does your child live in a household eligible for Medicaid, WIC, CHIP, or a state benefits program? Yes. No. Don't Know.
- Is your child a newly arrived refugee, immigrant, or a foreign adoptee? Yes. No. Don't Know.

❖ Corpsmen: check lead exposure risk zone based on address at: <https://fortress.wa.gov/doh/wtnibl/WTNIBL/>  
NOTIFY PROVIDER DURING TURNOVER of any "Yes" or "Don't Know" answers for TB or Lead Screens.

## Exceptional Family Member Program (EFMP)

|                                              |     |    |
|----------------------------------------------|-----|----|
| Is the patient enrolled in the EFMP program? | YES | NO |
|----------------------------------------------|-----|----|

Family history/Surgeries. Check all that apply.

| Family History                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Patient surgeries                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Asthma<br><input type="checkbox"/> Allergies<br><input type="checkbox"/> SIDS<br><input type="checkbox"/> Birth Defects<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Heart Attack<br>(before the age of 50)<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Vision Problems<br><input type="checkbox"/> Hearing Problems<br><input type="checkbox"/> Mental Health Concerns (ADHD,<br>Anxiety, Bipolar, Depression,<br>Intellectual Disability, Suicide, etc.)<br><input type="checkbox"/> Alcohol/Substance Abuse<br><input type="checkbox"/> Genetic/Metabolic Disease<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> NO History of Surgery<br><br><input type="checkbox"/> Ear Tubes<br><input type="checkbox"/> Tonsillectomy<br><input type="checkbox"/> Adenoidectomy<br><input type="checkbox"/> Circumcision<br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Other: _____ |
| <p><b>◆To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |

## Home Environment

Who does the patient live with? \_\_\_\_\_

|                                          |     |    |
|------------------------------------------|-----|----|
| Household alcohol concerns?              | YES | NO |
| Household members who Smoke              | YES | NO |
| Vape?                                    | YES | NO |
| Does the child attend Daycare/Preschool? | YES | NO |

**Please turn the page and complete the Developmental Questionnaire. Once you are done, please keep your paperwork with you and wait to be called back.**

\*\*\* If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! \*\*\*



# SWYC: 24 months

23 months, 0 days to 28 months, 31 days  
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

## DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

|                                                                         | Not Yet | Somewhat | Very Much |
|-------------------------------------------------------------------------|---------|----------|-----------|
| Names at least 5 body parts - like nose, hand, or tummy . . . . .       | 0       | 1        | 2         |
| Climbs up a ladder at a playground . . . . .                            | 0       | 1        | 2         |
| Uses words like "me" or "mine" . . . . .                                | 0       | 1        | 2         |
| Jumps off the ground with two feet . . . . .                            | 0       | 1        | 2         |
| Puts 2 or more words together - like "more water" or "go outside" . . . | 0       | 1        | 2         |
| Uses words to ask for help . . . . .                                    | 0       | 1        | 2         |
| Names at least one color . . . . .                                      | 0       | 1        | 2         |
| Tries to get you to watch by saying "Look at me" . . . . .              | 0       | 1        | 2         |
| Says his or her first name when asked . . . . .                         | 0       | 1        | 2         |
| Draws lines . . . . .                                                   | 0       | 1        | 2         |

## PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

|                                                              | Not at all | Somewhat | Very Much |
|--------------------------------------------------------------|------------|----------|-----------|
| <b>Does your child...</b>                                    |            |          |           |
| Seem nervous or afraid? . . . . .                            | 0          | 1        | 2         |
| Seem sad or unhappy? . . . . .                               | 0          | 1        | 2         |
| Get upset if things are not done in a certain way? . . . . . | 0          | 1        | 2         |
| Have a hard time with change? . . . . .                      | 0          | 1        | 2         |
| Have trouble playing with other children? . . . . .          | 0          | 1        | 2         |
| Break things on purpose? . . . . .                           | 0          | 1        | 2         |
| Fight with other children? . . . . .                         | 0          | 1        | 2         |
| Have trouble paying attention? . . . . .                     | 0          | 1        | 2         |
| Have a hard time calming down? . . . . .                     | 0          | 1        | 2         |
| Have trouble staying with one activity? . . . . .            | 0          | 1        | 2         |
| <b>Is your child...</b>                                      |            |          |           |
| Aggressive? . . . . .                                        | 0          | 1        | 2         |
| Fidgety or unable to sit still? . . . . .                    | 0          | 1        | 2         |
| Angry? . . . . .                                             | 0          | 1        | 2         |
| <b>Is it hard to...</b>                                      |            |          |           |
| Take your child out in public? . . . . .                     | 0          | 1        | 2         |
| Comfort your child? . . . . .                                | 0          | 1        | 2         |
| Know what your child needs? . . . . .                        | 0          | 1        | 2         |
| Keep your child on a schedule or routine? . . . . .          | 0          | 1        | 2         |
| Get your child to obey you? . . . . .                        | 0          | 1        | 2         |

**PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)**

|                                                                         |                                              |                                               |                                                |                                                   |                                |
|-------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------|------------------------------------------------|---------------------------------------------------|--------------------------------|
| Does your child bring things to you to show them to you?                | Many times<br>a day<br><input type="radio"/> | A few times<br>a day<br><input type="radio"/> | A few times<br>a week<br><input type="radio"/> | Less than<br>once a week<br><input type="radio"/> | Never<br><input type="radio"/> |
| Is your child interested in playing with other children?                | Always<br><input type="radio"/>              | Usually<br><input type="radio"/>              | Sometimes<br><input type="radio"/>             | Rarely<br><input type="radio"/>                   | Never<br><input type="radio"/> |
| When you say a word or wave your hand, will your child try to copy you? | <input type="radio"/>                        | <input type="radio"/>                         | <input type="radio"/>                          | <input type="radio"/>                             | <input type="radio"/>          |
| Does your child look at you when you call his or her name?              | <input type="radio"/>                        | <input type="radio"/>                         | <input type="radio"/>                          | <input type="radio"/>                             | <input type="radio"/>          |
| Does your child look if you point to something across the room?         | <input type="radio"/>                        | <input type="radio"/>                         | <input type="radio"/>                          | <input type="radio"/>                             | <input type="radio"/>          |

|                                                                        |                                              |                                     |                                           |                                            |                                                               |
|------------------------------------------------------------------------|----------------------------------------------|-------------------------------------|-------------------------------------------|--------------------------------------------|---------------------------------------------------------------|
| How does your child <u>usually</u> show you something he or she wants? | <b>Says a word for what he or she wants</b>  | <b>Points to it with one finger</b> | <b>Reaches for it</b>                     | <b>Pulls me over or puts my hand on it</b> | <b>Grunts, cries or screams</b>                               |
| <i>(please check all that apply)</i>                                   | <input type="checkbox"/>                     | <input type="checkbox"/>            | <input type="checkbox"/>                  | <input type="checkbox"/>                   | <input type="checkbox"/>                                      |
| What are your child's favorite play activities?                        | <b>Playing with dolls or stuffed animals</b> | <b>Reading books with you</b>       | <b>Climbing, running and being active</b> | <b>Lining up toys or other things</b>      | <b>Watching things go round and round like fans or wheels</b> |
| <i>(please check all that apply)</i>                                   | <input type="checkbox"/>                     | <input type="checkbox"/>            | <input type="checkbox"/>                  | <input type="checkbox"/>                   | <input type="checkbox"/>                                      |

For acknowledgments, validation, and other information concerning the POSI, please see [www.theswyc.org/posi](http://www.theswyc.org/posi)

**PARENT'S CONCERNS**

|                                                                      |                       |                       |                       |
|----------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
|                                                                      | <b>Not At All</b>     | <b>Somewhat</b>       | <b>Very Much</b>      |
| Do you have any concerns about your child's learning or development? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Do you have any concerns about your child's behavior?                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**FAMILY QUESTIONS**

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

|                                                                                                         |                           |                           |                                |                           |                           |                           |                           |                           |
|---------------------------------------------------------------------------------------------------------|---------------------------|---------------------------|--------------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
|                                                                                                         | <b>Yes</b>                | <b>No</b>                 |                                |                           |                           |                           |                           |                           |
| 1 Does anyone who lives with your child smoke tobacco?                                                  | <input type="radio"/> (Y) | <input type="radio"/> (N) |                                |                           |                           |                           |                           |                           |
| 2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?                   | <input type="radio"/> (Y) | <input type="radio"/> (N) |                                |                           |                           |                           |                           |                           |
| 3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?         | <input type="radio"/> (Y) | <input type="radio"/> (N) |                                |                           |                           |                           |                           |                           |
| 4 Has a family member's drinking or drug use ever had a bad effect on your child?                       | <input type="radio"/> (Y) | <input type="radio"/> (N) |                                |                           |                           |                           |                           |                           |
|                                                                                                         | <b>Never true</b>         | <b>Sometimes true</b>     |                                |                           |                           |                           |                           |                           |
| 5 Within the past 12 months, we worried whether our food would run out before we got money to buy more. | <input type="radio"/>     | <input type="radio"/>     |                                |                           |                           |                           |                           |                           |
|                                                                                                         | <b>Not at all</b>         | <b>Several days</b>       | <b>More than half the days</b> | <b>Nearly every day</b>   |                           |                           |                           |                           |
| Over the past two weeks, how often have you been bothered by any of the following problems?             |                           |                           |                                |                           |                           |                           |                           |                           |
| 6 Having little interest or pleasure in doing things?                                                   | <input type="radio"/> (0) | <input type="radio"/> (1) | <input type="radio"/> (2)      | <input type="radio"/> (3) |                           |                           |                           |                           |
| 7 Feeling down, depressed, or hopeless?                                                                 | <input type="radio"/> (0) | <input type="radio"/> (1) | <input type="radio"/> (2)      | <input type="radio"/> (3) |                           |                           |                           |                           |
|                                                                                                         | <b>No tension</b>         | <b>Some tension</b>       | <b>A lot of tension</b>        | <b>Not applicable</b>     |                           |                           |                           |                           |
| 8 In general, how would you describe your relationship with your spouse/partner?                        | <input type="radio"/>     | <input type="radio"/>     | <input type="radio"/>          | <input type="radio"/>     |                           |                           |                           |                           |
|                                                                                                         | <b>No difficulty</b>      | <b>Some difficulty</b>    | <b>Great difficulty</b>        | <b>Not applicable</b>     |                           |                           |                           |                           |
| 9 Do you and your partner work out arguments with:                                                      | <input type="radio"/>     | <input type="radio"/>     | <input type="radio"/>          | <input type="radio"/>     |                           |                           |                           |                           |
| 10 During the past week, how many days did you or other family members read to your child?              | <input type="radio"/> (0) | <input type="radio"/> (1) | <input type="radio"/> (2)      | <input type="radio"/> (3) | <input type="radio"/> (4) | <input type="radio"/> (5) | <input type="radio"/> (6) | <input type="radio"/> (7) |

**(Below for Office Staff)**

Weight: \_\_\_\_\_ kg

Length: \_\_\_\_\_ cm

Head Circumference: \_\_\_\_\_ cm

Heart Rate: \_\_\_\_\_ bpm

Pediavision Results:

**L** \_\_\_\_\_ DS: \_\_\_\_\_ DC: \_\_\_\_\_ Axis: \_\_\_\_\_

**R** \_\_\_\_\_ DS: \_\_\_\_\_ DC: \_\_\_\_\_ Axis: \_\_\_\_\_

Lead Exposure Risk Zone: \_\_\_\_\_

Respiratory Rate: \_\_\_\_\_ breaths/min

O2 sat (if indicated): \_\_\_\_\_

Temperature: \_\_\_\_\_  
(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

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# PARENT HANDOUT

## 2 Year Old Health Supervision

### Your child's growth:

Weight: \_\_\_\_\_ lb. Percentile: \_\_\_\_\_

Height: \_\_\_\_\_ in. Percentile: \_\_\_\_\_

Head Circumference: \_\_\_\_\_ cm.

#### Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process



### Eating

- Food likes and dislikes may vary.
- Diet should be balanced over time.
- Give your child many chances to try a new food.

Click on me to go to the  
"HealthyChildren.org" Website!  
An American Academy of Pediatrics  
(AAP) guide to your child's milestones,  
growth and development. Search by age.



### Your Changing Child

- Follow a regular bed-time routine and schedule. Minimize interaction at night during awakenings.
- Avoid the use of computers, TV, or videos to 1-2 hours or less each day.
- Sing, speak and read to your child often.
- Set limits that are important to you and ask others to use them with your child.
- Help your child express their feelings and name them.
- Keep time-outs brief. Tell your child in simple words what they did wrong.
- Let your child choose between 2 good things for food, drinks, or books.
- Brush teeth twice daily. Only give water after brushing teeth at night.
- Take your child for a first dental visit if you have not done so.
- Signs of being ready for toilet training are: being dry for 2 hours, knowing when they are wet or dry, can tell you when they are going to have a bowel movement, and show interest in learning.

### Safety

- Be sure your child's car safety seat is correctly installed.
- Keep your car and home smoke free.
- Have your child wear a good-fitting helmet on bikes and trikes.
- Never leave your child alone near water.
- Lock up poisons, medicines, and cleaning supplies. Call Poison Control at 1-800-222-1222 if you need them.

### Immunizations

- Annual Influenza (2 doses for first time influenza vaccination)

### When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: <https://centercitypediatrics.com/wait-worry-panic/>

**Next health supervision appointment:** 30 Months

### Patient specific guidance:

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