Patient intake for 30-MONTH-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 deployed or on extended duty outside of the immediate area?	**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.

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 ive 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
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
♦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.	

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

<u>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.</u>

***** 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™: 30 months

29 months, 0 days to 34 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 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
Talks so other people can understand him or her most of the time	0	1	2
Washes and dries hands without help (even if you turn on the water)	0	1	2
Asks questions beginning with "why" or "how" - like "Why no cookie?"	0	1	2
Explains the reasons for things, like needing a sweater when it's cold	0	1	2
Compares things - using words like "bigger" or "shorter"	0	1	2
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	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
Does your child...	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
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	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

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********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	○	○	○	○	○

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	○	○	○	○	○
When you say a word or wave your hand, will your child try to copy you?	○	○	○	○	○
Does your child look at you when you call his or her name?	○	○	○	○	○
Does your child look if you point to something across the room?	○	○	○	○	○

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

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

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	(Y)	(N)
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	(Y)	(N)
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	(Y)	(N)
4 Has a family member's drinking or drug use ever had a bad effect on your child?	(Y)	(N)

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	(0)	(1)	(2)	(3)
7 Feeling down, depressed, or hopeless?	(0)	(1)	(2)	(3)

8 In general, how would you describe your relationship with your spouse/partner?	No tension ○	Some tension ○	A lot of tension ○	Not applicable ○
9 Do you and your partner work out arguments with:	No difficulty ○	Some difficulty ○	Great difficulty ○	Not applicable ○

10 During the past week, how many days did you or other family members read to your child? (0) (1) (2) (3) (4) (5) (6) (7)

(Below for Office Staff)

Weight: _____kg

Height: _____cm

Heart Rate: _____ bpm

Respiratory Rate: _____ breaths/min

O2 sat (if indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Pediavision Results:

L _____ DS:_____ DC:_____ Axis: _____

R _____ DS:_____ DC:_____ Axis: _____

Lead Exposure Risk Zone: _____

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

30 Month Health Supervision

Your child's growth:

Weight:_____lb. Percentile:_____

Height: _____in. Percentile:_____

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

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.

Eating

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

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 care 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: 3 Years Old

Patient specific guidance:

_____

_____

_____