



# FAMILY HEALTH

A S S O C I A T E S

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## PEDIATRIC HEALTH MAINTENANCE – 2 YEARS PATIENT QUESTIONNAIRE

### General

Do you have any concerns about your child? Yes \_\_\_ No \_\_\_

If “yes,” please specify:

Is your child in daycare or in the care of a babysitter? Yes \_\_\_ No \_\_\_

Do you have any concerns about your child’s vision or hearing? Yes \_\_\_ No \_\_\_

Do your child’s eyes ever appear to cross or drift apart? Yes \_\_\_ No \_\_\_

Does your child use bottles or pacifiers? Yes \_\_\_ No \_\_\_

### Feeding and Sleeping

What type of milk does your child drink?  Whole  1 or 2%  Skim  Other: \_\_\_\_\_

How much milk does your child drink each day? \_\_\_\_\_

Does your child eat a good variety of foods? Yes \_\_\_ No \_\_\_

Do you eat meals as a family? Yes \_\_\_ No \_\_\_

Do you brush your child’s teeth twice a day? Yes \_\_\_ No \_\_\_

Does your child sleep through the night? Yes \_\_\_ No \_\_\_

Do you think your child’s bowel movements are normal? Yes \_\_\_ No \_\_\_

### Environment

Who lives with you in your home? \_\_\_\_\_

Do you have pets? Yes \_\_\_ No \_\_\_

Does anyone smoke in your house? Yes \_\_\_ No \_\_\_

### Safety

Do you give your child raw vegetables, hard candy, gum, nuts, or popcorn? Yes \_\_\_ No \_\_\_

Are your windows locked? Are any guns in your home securely stored? Yes \_\_\_ No \_\_\_

Are all medicines, household products, and sharp objects locked up? Yes \_\_\_ No \_\_\_

Do you have a pool? Yes \_\_\_ No \_\_\_

Do you leave your child alone in the bath? Yes \_\_\_ No \_\_\_

Is your child ever in the yard when a lawnmower is in use? Yes \_\_\_ No \_\_\_

Does your baby ride in a rear-facing car seat, in the back seat? Yes \_\_\_ No \_\_\_

Are you afraid of your partner or anyone close to you? Yes \_\_\_ No \_\_\_

Do you feel overly stressed or unsupported? Yes \_\_\_ No \_\_\_

Patient Name: \_\_\_\_\_

Completed by (name and relationship to patient): \_\_\_\_\_ Date: \_\_\_\_\_



# Ages & Stages Questionnaires®

## 24 Month Questionnaire

23 months 0 days through 25 months 15 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: \_\_\_\_\_

### Child's information

Child's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Child's last name: \_\_\_\_\_

Child's gender:  
 Male  Female

Child's date of birth: \_\_\_\_\_

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship to child:

- Parent  Guardian  Teacher  Child care provider
- Grandparent or other relative  Foster parent  Other: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Names of people assisting in questionnaire completion: \_\_\_\_\_

### Program Information

Child ID #: \_\_\_\_\_

Program ID #: \_\_\_\_\_

Program name: \_\_\_\_\_



# 24 Month Questionnaire

23 months 0 days  
through 25 months 15 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

### Important Points to Remember:

### Notes:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.
- Please return this questionnaire by \_\_\_\_\_.

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At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

## COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" ( <i>She needs to identify only one picture correctly.</i> )	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? ( <i>Mark "yes" even if her words are difficult to understand.</i> )	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Without your giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/> a. "Put the toy on the table." <input type="radio"/> d. "Find your coat." <input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand." <input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."				
4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly <i>name</i> at least one picture?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? ( <i>Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?"</i> ) Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**COMMUNICATION** (continued)

6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL \_\_\_\_\_

**GROSS MOTOR**

1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "yes" for this item.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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4. Does your child run fairly well, stopping herself without bumping into things or falling?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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5. Does your child jump with both feet leaving the floor at the same time?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?



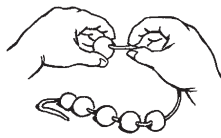
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*
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GROSS MOTOR TOTAL \_\_\_\_\_

\*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."

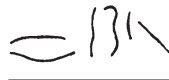
**FINE MOTOR**

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your child turn the pages of a book by herself? (She may turn more than one page at a time.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your child flip switches off and on?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child stack seven small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				<b>FINE MOTOR TOTAL</b> ___

**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET	
1. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "not yet" if your child scribbles back and forth.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.) (You can use a soda-pop bottle or baby bottle.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

Count as "yes"

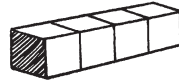


Count as "not yet"



**PROBLEM SOLVING** *(continued)*

6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? (You can also use spools of thread, small boxes, or other toys.)



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

PROBLEM SOLVING TOTAL \_\_\_\_\_

**PERSONAL-SOCIAL**

1. Does your child drink from a cup or glass, putting it down again with little spilling?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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3. Does your child eat with a fork?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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4. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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PERSONAL-SOCIAL TOTAL \_\_\_\_\_

**OVERALL**

*Parents and providers may use the space below for additional comments.*

1. Do you think your child hears well? If no, explain:

YES       NO

2. Do you think your child talks like other toddlers her age? If no, explain:

YES       NO

**OVERALL** (continued)

3. Can you understand most of what your child says? If no, explain:

 YES NO

4. Do you think your child walks, runs, and climbs like other toddlers his age?  
If no, explain:

 YES NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

 YES NO

6. Do you have any concerns about your child's vision? If yes, explain:

 YES NO

7. Has your child had any medical problems in the last several months? If yes, explain:

 YES NO

**OVERALL** *(continued)*

8. Do you have any concerns about your child's behavior? If yes, explain:

YES

NO

9. Does anything about your child worry you? If yes, explain:

YES

NO





# 24 Month ASQ-3 Information Summary

23 months 0 days through  
25 months 15 days

Child's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_  
 Child's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Administering program/provider: \_\_\_\_\_

**1. SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	25.17		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	○	○	○	○	○	○	○

**2. TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |  |     |            |  |            |    |
|--|-----|------------|--|------------|----|
| 1. Hears well?<br>Comments:                                  | Yes | <b>NO</b>  | 6. Concerns about vision?<br>Comments:   | <b>YES</b> | No |
| 2. Talks like other toddlers his age?<br>Comments:           | Yes | <b>NO</b>  | 7. Any medical problems?<br>Comments:    | <b>YES</b> | No |
| 3. Understand most of what your child says?<br>Comments:     | Yes | <b>NO</b>  | 8. Concerns about behavior?<br>Comments: | <b>YES</b> | No |
| 4. Walks, runs, and climbs like other toddlers?<br>Comments: | Yes | <b>NO</b>  | 9. Other concerns?<br>Comments:          | <b>YES</b> | No |
| 5. Family history of hearing impairment?<br>Comments:        |     | <b>YES</b> | No                                       |            |    |

**3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the  area, it is above the cutoff, and the child's development appears to be on schedule.  
 If the child's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.  
 If the child's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

**4. FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in \_\_\_\_\_ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): \_\_\_\_\_

**5. OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



# FAMILY HEALTH ASSOCIATES

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## Well Child: 2 Years

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Length: \_\_\_\_\_ in. ( \_\_\_\_\_ %)

Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. ( \_\_\_\_\_ %) Head Circumference: \_\_\_\_\_ cm. ( \_\_\_\_\_ %)

IMMUNIZATIONS: Hep A (2<sup>nd</sup> dose if 6 or more months since 1<sup>st</sup>)

### IBUPROFEN (Advil, Motrin) & ACETAMINOPHEN (Tylenol) DOSAGE

Child's Weight	Ibuprofen Infant Dose (50 mg/1.25mL)	Acetaminophen Infant's Suspension (160mg/5mL)
18-23lbs	1.87mL	3.75mL
24-35lbs	1.25mL + 1.25mL	5mL
36-47lbs	1.25mL + 1.25mL	7.5mL
48-59lbs	5mL	10mL

**Ibuprofen** may be given every 6 hours, but not more than 4 times in 24 hours. CHECK THE CONCENTRATION OF THE IBUPROFEN YOU ARE USING

**Acetaminophen** may be given every 4 hours, but not more than four times in 24 hours. Please call the office if fever persists for more than 2 days or if you have any questions.

**NEXT VISIT:** 2.5 Years

#### How Your Family is Doing

- Take time for yourself and your partner.
- Stay in touch with friends.
- Make time for family activities. Spend time with each child.
- Teach your child not to hit, bite, or hurt other people. Be a role model.
- If you feel unsafe in your home or have been hurt by someone, let us know. Hotlines and community resources can also provide confidential help.
- Don't smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy.
- Don't use alcohol or drugs.
- Accept help from family and friends.
- If you are worried about your living or food situation, reach out for help. Community agencies and programs such as WIC and SNAP can provide information and assistance.

#### Talking and Your Child

- Use clear, simple language with your child. Don't use baby talk.
- Talk slowly and remember that it may take a while for your child to respond. Your child should be able to follow simple instructions.
- Read to your child every day. Your child may love hearing the same story over and over.
- Talk about and describe pictures in books.
- Talk about the things you see and hear when you are together.
- Ask your child to point to things as you read.
- Stop a story to let your child make an animal sound or finish a part of the story.

### Safety

- Make sure your child's car safety seat is rear facing until they reaches the highest weight or height allowed by the car safety seat's manufacturer. Once your child reaches these limits, it is time to switch the seat to the forward facing position.
- Make sure the car safety seat is installed correctly in the back seat. The harness straps should be snug against your child's chest.
- Children watch what you do. Everyone should wear a lap and shoulder seat belt in the car.
- Never leave your child alone in your home or yard, especially near cars or machinery, without a responsible adult in charge.
- When backing out of the garage or driving in the driveway, have another adult hold your child a safe distance away so they are not in the path of your car.
- Have your child wear a helmet that fits properly when riding bikes and trikes.
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately.
- **IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222**

### Your Child's Behavior

- Praise your child when they do what you ask him to do.
- Listen to and respect your child. Expect others to do as well.
- Help your child talk about their feelings.
- Watch how they respond to new people or situations.
- Read, talk, sing, and explore together. These activities are the best ways to help toddlers learn.
- Limit TV, tablet, or smartphone use to no more than 1 hour of high-quality programs each day.
  - It is better for toddlers to play than to watch TV.
  - Encourage your child to play for up to 60 minutes a day.
- Avoid TV during meals. Talk together instead.

### Toilet Training

- Begin toilet training when your child is ready. Signs of being ready for toilet training include
  - Staying dry for 2 hours
  - Knowing if they are wet or dry
  - Can pull pants down and up
  - Wanting to learn
  - Can tell you if they are going to have a bowel movement
- Plan for toilet breaks often. Children use the toilet as many as 10 times each day.
- Teach your child to wash their hands after using the toilet.
- Clean potty-chairs after every use.
- Take the child to choose underwear when they feel ready to do so.

### **WHAT TO EXPECT AT YOUR CHILD'S 2 ½ Year VISIT**

We will talk about:

- Creating family routines
- Supporting your talking child
- Getting along with other children
- Getting ready for preschool
- Keeping your child safe at home, outside, and in the car