SWYC:™ 36 months

35 months, 0 days to 46 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
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
Tells you a story from a book or tv	0	1	2
Draws simple shapes - like a circle or a square	0	1	2
Says words like "feet" for more than one foot and "men" for more than one man	0	1	2
Uses words like "yesterday" and "tomorrow" correctly	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

Floating Hospital for Children at Tufts Medical Center

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

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)

blackmon pediatrics

Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? _____

Can you describe your child's nutritional habits?

1. Milk:	Whole	Low-fat	Soy	
2. Appetite:	Good	Variable	Picky	
3. Water Source:	City	Well	Spring	Bottled
4. Variety of foods	Fruits	Veggies	Breads	Meats
5. Multivitamin with iron	Yes	No		
6. Eats Breakfast:	Yes	No		
7. Eats supper as family	Yes	No		

Is there any problems with hearing and vision?

1. Do you have concerns about how your child sees? Yes No
2. Has your child failed a school vision test? Yes No
3. Does your child tend to squint? Yes No
4. Do you have concerns about how your child hears? Yes No
5. Do you have concerns about how your child speaks? Yes No

Has there been any foreign travel in the past 60 days or foreign adoption? Yes No

Has there been any exposure to smoking? Yes No Who: _____

Lead Screening (please answer for ages 2 year, 3 year, 4 year, 5 year, and 6 year)

1. Does your child live in or regularly visit a house built before 1950? Yes No
2. Does your child live in or regularly visit a house built before 1978 with recent renovations? Yes No
3. Does your child have a sibling or playmates that have or have had lead poisoning? Yes No
4. Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking? Yes No

Immunizations

1.Previous reaction to immunizations	Yes	No
2.Have family members been immunized (mom, dad, sibling)	Yes	No
3.History of chicken pox in child being seen	Yes	No
4.Serious illness at home or relatives (cancer)	Yes	No
5.Allergic to eggs, gelatin, Neomycin, yeast	Yes	No

Please describe your social history.

1. Race: _____
2. Language: _____
3. Lives With: _____
4. Ethnicity: _____
5. # Siblings: _____

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes No Specify: _____

Have there been any changes in your child's medical needs?

1. New Problems or illness Yes No Specify: _____
2. Please list current medications (prescription and over-the-counter) _____