Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

15 – 18 Month Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have any concerns about any of the following for your child? . ... Y N
   eating sleeping vision hearing
2. Does your child eat a variety of health foods? .... Y N
3. Have you noticed any reactions to foods, medications or other exposures? .... Y N
4. Do you brush your child's teeth? .... Y N
5. Do you and your partner agree on rules/discipline? .... Y N
6. Has your child had any injuries since the last visit? .... y N

SAFETY

7. Do you use a car seat in the back seat every time your child rides in the car? .... Y N
8. Is there a gun in your home? .... Y N
   If yes, is it locked?.. Y N
9. Do you know first aid for burns? .... Y N
10. Have you child-proofed your home? .... Y N
11. Do you have the poison control phone number (1-800-222-1222) handy? ……………..Y N
12. Do you feel safe in your neighborhood? .... Y N
13. Does anyone that cares for your child smoke? .... Y N

SOCIAL

14. Have you been in a relationship where you were hurt, threatened, or treated badly? . Y N
15. Have you been concerned that someone could hurt your child? .... Y N
16. Are there any new stresses or recent changes impacting your family
    (job change, move, divorce, illness)? .... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date