

2 YEAR WELL CHILD VISIT

Hirsch Holistic Family Medicine

3525 Ensign Rd NE Ste N

Olympia WA 98506

(360) 464-9965 / (800) 897-8320 fax

Patient name: _____ Date _____ Age _____

Accompanied by: _____ Birthdate _____

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES

- Yes No Overall, I feel confident that my child is doing well
Yes No I have enough help with parenting responsibilities
No Yes There have been recent changes or stresses in our family
No Yes I have concerns about sibling conflicts
No Yes My child attends daycare
No Yes My toddler's behavior is very challenging
No Yes I have questions about tantrums or discipline
-
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NUTRITION/SLEEP

- No Yes I have questions about my child's eating habits
Yes No My child eats a balanced diet
No Yes My child uses a bottle for milk or juice
Yes No I am happy with my child's sleep schedule
Yes No We use a consistent bedtime routine
Yes No My child sleeps in his/her own bed
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VOIDING/STOOLING

- No Yes I have questions about toilet training
No Yes My child has hard or painful bowel movements
-
-

DEVELOPMENT

- No Yes I have questions about my child's development
Yes No My child understands most of what I say
Yes No My child uses at least 20 words
Yes No My child combines two words
Yes No My child likes to imitate adults
Yes No My child enjoys "pretend" games
Yes No My child can kick and throw a ball
Yes No My child walks up stairs
Yes No My child likes to draw with crayons
Yes No I read to my child every day
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PREVENTION

- No Yes My child lives with someone who smokes cigarettes
No Yes My child or another person living with us was born outside the U.S. or has traveled to Asia, Mexico, Latin America, or Africa
No Yes I have a family member who has had Tuberculosis
Yes No I always keep my child in a car seat when driving
No Yes We have a gun at home
Yes No Tools and matches are kept out of reach
Yes No I use sunscreen to protect my child's skin
Yes No My child has been to the dentist
Yes No I help my child brush his/her teeth
Yes No I give fluoride supplements daily
No Yes Is there anything else you want to discuss today?
-
-

DISCUSSION TOPICS

Parenting support
Time-out procedures
Parenting consistency
Setting limits
Emerging autonomy
Appropriate self-expression
Conflict resolution
Praise

Wean from bottle
Vit D, calcium, fiber, iron sources
Limit juice intake
2% milk <16 oz/day
Avoid sweets
Avoid mealtime struggles

Toilet training readiness

RPDQ if concerns
Encourage language development
Limit screen time

Promote physical activities
Playmates
Reading routines

Risk of tobacco exposure
Assess TB risk

Full car seat until 40# / Back seat
Firearms stored safely
Accident prevention/supervision
Childproof home
Limit sun exposure
Water safety
Tooth care routines
Ingestion prevention
Poison control 800-222-1222
Injuries are the #1 cause of death

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PHYSICAL EXAM: (all items examined unless crossed out. Abnormalities circled and commented on)

Height: _____ cm (_____ %)
 Weight: _____ kg (_____ %)
 OFC: _____ cm (_____ %)
 T: _____
 P: _____
 RR: _____

General Appearance:	cooperative, no apparent distress,	normal tone, DTRs 2+ symmetric
Skin:	social	
HEENT:	no lesions	_____
	nares clear, TMs pearly, PERRL	_____
	nmnl cover test, normal oropharynx,	_____
Neck:	teeth w/o caries	_____
Lungs:	no adenopathy or thyromegaly	_____
CV:	clear to auscultation	_____
	normal S1, S2, RRR without murmur	_____
Abdomen:	normal femoral pulses	_____
Extremities:	soft, no hepatosplenomegaly or	_____
Genitourinary:	masses	_____
Neurologic:	hips >60 deg abduction b/l, normal	_____
	gait	_____
	normal male/female external genitalia	_____

ASSESSMENT:	PLAN:
1. Growth and developmental progress o Normal for age o Concerns _____	_____
2. Immunizations	o Discussed recommended schedules, risks and benefits. o DtaP #____ o Varicella o MMR #____ o Hep A #____ o _____
3. Dental Health o Good o At risk o Caries	o Reviewed preventive measures o Fluoride 0.25 mg/day o ABCD referral
4. Tobacco Smoke Exposure o Yes o No	o Cessation counseling o Exposure avoidance o Referral _____
5. Screening (safety, anemia, family, TB, lead, Vit D) o No risk factors identified o Risk factors _____	o Vit D Supplement o Lead level (if at high risk) o _____
6. _____	6. _____
7. _____	7. _____

Next visit at 3 years
 o Problem list updated o Allergies updated
 o Med list updated o See dictated note

Mortality Leaders: Accidental injuries due to falls, drowning, burns, choking, auto accidents

 Provider Signature

 Date

 Preceptor Signature