（受付番号　　）　健診日

	希望	相談内容	済
内科相談			
栄養相談			
歯みがき相談			
ことば・発達相談			

18 month old Health Checkup Questionnaire

※Please leave this sheet at the checkup place when you come.
Please fill inside the thick-frame box.(Front and back)
Please circle those that apply.

Name		Male / Female	Date of birth	/ / (1 year and _____months)	
Name of the parent or a guardian		Address			
Family member	Father / Mother / Older brother (years old) / Older sister (years old)				
	Younger brother (years old) / Younger sister (years old) / Other ( )				
Phone	(Father / Mother)	【Possibility of mother's pregnancy】 No / Yes (Due date)			

【Who takes care of the baby during the day?】
Father / Mother / Grandparent(s) / Day-care center / Kindergarten / Nintei Kodomoen / Private day-care place / Other

【 Developmental history 】
Length of pregnancy(weeks) Weight at birth(g)
Did you have any sickness or problems during pregnancy and delivery? No / Yes ( )
Your child's development thus far Stable neck (months) Turning over (months)
Unsupported sitting (months) Unsupported walking (months)

1	Circle the illness your child had since birth.(Chicken Pox / Mumps / Pertussis / Measles / Rubella)				
2	Hib(Hemophilic influenza type b vaccine) 1st / 2nd / 3rd / Additional	Childhood pneumococcal vaccination 1st / 2nd / 3rd / Additional	Hepatitis B vaccine 1st / 2nd / 3rd		
	Diphtheria,pertussis,tetanus,and polio 1st / 2nd / 3rd / Additional	BCG (Tuberculocis)	Measles and rubella	Varicella(Chickenpox) 1st / 2nd	rotavirus 1st / 2nd / 3rd
3	Went to a hospital due to an accident or major injury? (Fall / Bruise / Cut / Accidental ingestion / Near-drowing / Traffic accident / Burn / Oth			Yes	No
4	Any major illness or disease If Yes , what is it? ( )			Yes	No
5	Is your child currently being treated for an illness or allergy? If Yes , what is it? （ ）			Yes	No
6	Is there anything you would like to talk about or worried about? Sleep / Diet / Excretion (peeing and pooping) /Dental/ Speaking ability / Other			Yes	No

＜About growth and development＞ Please circle those that apply.

1	Does your child walk smoothly and rarely fall?	Yes	No
2	Does your child pick small things such as button with his/her thumb and an index finge	Yes	No
3	Can your child go up the stairs if you hold his/her hand?	Yes	No
4	Does your child scribble with crayons and such?	Yes	No
5	Does your child answer your questions by pointing when you ask where things are?	Yes	No
6	Does your child say two or three things that adults can understad?	Yes	No
7	What does your child say? （ ）		
8	What does your child do when he/she wants somethings? (Check all that applies)		

- ☐ He/She does not do anything.
- ☐ He/She pulls or pushes his/her mom.
- ☐ He/She points at things.
- ☐ He/She can tell you what he/she wants verbally.

9	Is there anything that he/she stopped doing or cannot do anymore? ( ) e.g.) He/She does not mimic people as much as before. He/She cannot say certain words that he/she used to be able to say.	No	Yes
10	Do you feel that you cannot understand what kind of your child he/she is?	No	Yes
11	Circle all things that you are concerned about. ☐ You rarely have eye contacts. ☐ Your child does not get clingy with you. ☐ Your child cannot stay still for a second. ☐ Your child cries at night a lot. ☐ Your child has a habit that you want him/her to stop. e.g.) finger sucking / Other ( )		
12	Does your child show interest in children around him/her?	Yes	No
13	Does your child get excited when you play with him/her?	Yes	No
14	Does your child mimic people?	Yes	No
15	Give an example of what your child likes to do? ( )		
16	Does your child trun his/her head when you call his/her name?	Yes	No
17	Do you have any concerns about his/her eye sight or hearing?	No	Yes

＜Child-rearing affairs＞ Please circle those that apply.

1	Do you enjoy raising your child?	Yes	Hard to say		No
2	Do you feel that raising a child is tiring?	Yes	Hard to say		No
3	Do your family members play with the child much?	Yes	Hard to say		No
4	Do you have anyone to talk about raising the child? If yes,who are they? Your spouse / Parent(s) / Friend(s) / Other( )			Yes	No
5	How is your physical and mental health?	Yes	Hard to say		Not good
6	Does the child’s mother smoke currently?		No	Yes (/ day)	
7	Does the child’s father smoke currently?		No	Yes (/ day)	
8	Are you aware of the fact that most children between the age of 18 months and 2 years try to tell you with pointing a finger when interested in something?			Yes	No
9	Do you have a child proof door on the bathroom entrance?	Yes	No		Not applicable
10	Does the child’s mother have plenty of relaxed time to spend with her child?	Yes	No		Hard to say
11	Is the child’s father involved in childcare / upbringings?	Often	Sometimes		
		Hardly any	Hard to say		
12	Do you feel any difficulties with childcare / upbringings?	Always	Sometimes		Not at all
13	If you answer "Always" or "Sometimes" in the previous questions: Do you know any solutions, for example you know where to get help?			Yes	No

14	Would you like to bring up your child in this area in the future?	(1)Yes (2)Probably (3)Unlikely (4)No
15	Please circle any of the events on the right which apply to your family within the last few months.	(1)Gave too much discipline (2)Smacked child when angry (3)Left child home alone (4)Did not give any meal for a prolonged time (5)Yelled at child emotionally (6)Covered child’s mouth (7)Shook child hard (8)None of the above

＜Dental condition＞ Please circle those that apply.

1	Are there any wobbly or missing teeth? (1)Yes (4)No
2	Does your child brush his/her teeth? After breakfast (1)Every day (2)Sometimes (3)Never After dinner (1)Every day (2)Sometimes (3)Never
3	After your child brush his/her teeth, do you do a follow-up brushing? (1)Every day (2)Sometimes (3)Never
4	Does the parent finish off brushing teeth for the child? (1)Finish brushing after the child brushes (2)Parent brushes teeth for the child (3)Child brushes own teeth alone (4)Neither child or parent brush the child’s teeth

＜About lifestyle and diet＞ Please circle those that apply.

1	Does your child get up around the same time every day? (1)Yes.(at :) (2)No
2	Does your child go to bed around the same time every day? (1)Yes.(at :) (2)No
3	Is there anything you are worried about regarding your child's habits? (1)No (2)Yes If Yes , what is it? ( )
4	How many hours a day does your child spend watching TV, videos, tablets and smartphones? (About hours)
5	Has the child finished with drinking breast milk? (1)Yes (year and months) (2)No (3)Never drank breast milk
6	Does he/she use a baby bottle? (1)Yes (year and months) (2)No (3)Never drank breast milk
7	Do you put a child to sleep with a baby bottle? (1)Yes (because) (2)No
8	Does he/she use a cup by him/herself? (1)Yes (2)No
9	Does he/she try to use a spoon,fork and eat by him/herself? (1)Yes (2)No
10	Does your child have a good appetite? (1)Yes (2)No (because) (3)It depends (because)
11	Does he/she chew his/her food properly? (1)Yes (2)Swallows without chewing much (3)Keeps the food in the mouth

12 Is your child a picky eater? If so, circle the food the child does not eat.
(1)Yes： Milk / Dairy product / Meat / Fish / Egg / Soy product / Vagetables / Potatoes / Other
(2)No,my child is not a picky eater.

13 Does your child concentrate on eating at meal times?
(1)Yes (2)No（Watch TV / Play / Curious about his/her surroundings / Other[ ])

14 Does your child have a meal times around the same time every day?
(1)Breakfast Yes（about :) No (because)
(2)Lunch Yes（about :) No (because)
(3)Dinner Yes（about :) No (because)

15 How long does your child take to finish eating ?
(1)Less than 10 min (2)Less than 30 min (3)30 min or more

16 How many times does your child have snacks (including juice) a day? (／day)

17 Is there a specific time for having snacks (including juice)?
(1)Yes. (2)No.Give it as much as he/she wants.

18 Is there a specific amount of snacks (including juice)?
(1)Yes. (2)No.Give it as much as he/she wants.

19 Circle the snacks you often give.
Bread / Rice ball / Potatoes / Fruits / Dried sardine / Biscuit / Rice cracker / Snacks
Chocolate / Ice cream / Jelly / Dairy product / Candy / Chewing gum
Chewing candy / Milk / Lactobacillus beverage / Soft drink / Juice / Other

20 Do you feed your child a snack after dinner before going to bed?(Other than water or tea)
(1)Yes（Snack / Fruits / Milk / Soft drink or Juice / Other[ ]) (2)No

21 Please draw a circle in an appropriate box.

	Egg	Meat / Fish / Processd food	Soy /Soy product	Milk /Dairy product	Light-colored vegetables	Green and yellow vegetables	Potatoes	Fruits
Does not eat so much								
About 3 times a week								
Almost every day								

22 Are you interested in making meals?
(1)Yes (2)Not so much. (3)No

23 Leave a comment if you have any concerns about meals.

※To parents/guardians

To support your child's healthy growth and development, we may contact related organizations like nursery schools regarding the results of the checkup etc. (Agree/Disagree)

栄 養 相 談

管理栄養士氏名
( )