

Child's Name: _____ Date of Birth: _____

Diagnosis: _____

Allergies: _____

Medications: _____

Today's Date: _____ Form Completed By: _____

Please answer the following questions about your child's health and development so we can help with your needs.

Staff Only	Staying Healthy	YES	SOME -TIMES	NO
F/U	Medical Home: _____			
	1. Do you have a medical home (family doctor or clinic) that you go to when your toddler is sick or needs a check-up?			
	2. Does your toddler have regular check-ups with the medical home provider?			
	3. Are your toddler's immunizations up-to-date?			
	4. Are you happy with your toddler's weight?			
	5. Can your toddler fall asleep without drinking from a bottle?			
	6. Do you or your toddler brush his/her teeth at least daily?			
	7. Does your toddler take two naps a day and sleep 9-12 hours at night?			
	8. Does your toddler have a soft-formed bowel movement on a regular basis? (usually every other day)			
	9. Do you regularly fasten your toddler into a car seat?			
	10. Do you understand the dangers of second-hand smoke on children?			

Name: _____ ID #: _____

<i>Staff Only</i> F/U	Managing Your Toddler's Healthcare Drugstore: _____	YES	SOME -TIMES	NO
	11. Do you understand your toddler's health problems?			
	12. Do you participate in your toddler's treatment? (medications, exercises, therapy)			
	13. Are you being taught how to do your toddler's treatments?			
	14. Are you continuing your toddler's treatments at home when the healthcare providers aren't present?			
	15. Do you feel that your toddler's identified needs are being met?			
	16. Do you know when, how much, and why your toddler gets medications? (prescription and over-the-counter, like <i>Tylenol</i>)			
	17. Do you know the side effects of your toddler's medications?			
	18. Are you able to get the medications, supplies, and/or equipment your toddler needs?			
	19. Do you know how to use your toddler's insurance and/or medical card?			
<i>Staff Only</i> F/U	Becoming Independent	YES	SOME -TIMES	NO
	20. Is your toddler beginning to practice self-care activities? (such as feeding self, brushing teeth, dressing)			
	21. Is your toddler learning to help around the house? (pick-up toys)			
	22. Are you happy with your toddler's toileting routine?			

Name: _____ ID #: _____

Staff Only F/U	Interacting with Others	YES	SOME -TIMES	NO
	23. Is your toddler able to communicate with others?			
	24. Have you begun to think about your toddler's future?			
	25. Do you and your toddler get to have some fun together every day? (playing together, reading, singing)			
	26. Does your toddler get to experience things outside of your home? (going with you on errands, meeting new people)			
	27. Do you have time to take care of some of your own needs?			
Staff Only F/U	Children's Rehabilitation Service Satisfaction	YES	SOME -TIMES	NO
	28. Are you pleased with the care you receive at CRS?			

What would you like to see done differently:

Information You Would Like to Have:

- Growth & Development
- Assistance Programs
- Social Security
- Early Intervention
- Medicaid
- Transportation
- Health Information
- Counseling
- Other: _____

Your Comments:

