McLaren Medical Group

WELL CHILD EXAM-EARLY CHILDHOOD: 3 Years

DATE	PATIENT NAME	DOB

Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

Yes	No	
☐	☐	Please tell me any concerns about the way your child is behaving or developing _____
☐	☐	My child is able to play by him/herself for short periods of time.
☐	☐	My child is able to leave me when in a known place.
☐	☐	My child enjoys playing with other children.
☐	☐	My child can tell when others are happy, mad or sad.
☐	☐	My child can copy a circle.
☐	☐	My child eats a variety of foods.
☐	☐	My child knows his/her name, age and sex.
☐	☐	My child can jump off a step with both feet.

Ask the parent to respond to the following statements:

Yes	No	
☐	☐	I have people who assist me when I have questions or need help.
☐	☐	I am enjoying my time with my child.
☐	☐	I have time for myself, partner and friends.
☐	☐	I feel safe with my partner.
☐	☐	I feel confident in parenting.

Provider to follow up as necessary

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool. Tool Used:_____).

Child Development			Parent Development		
Dresses self	Yes	No	Appropriately disciplines child	Yes	No
Rides a tricycle	Yes	No	Parent is loving toward Child.	Yes	No
Is understandable to others 75% of the time	Yes	No	Positively talks, listens, and responds to child.	Yes	No
Shows preference for parent or caregiver	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Seeks comfort from parent when upset	Yes	No			

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____

Provider Signature: _____

Date: _____ **Time:** _____

Patient Name:

Date of Birth: