McLaren Medical Group

WELL CHILD EXAM-EARLY CHILDHOOD: 4 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 learning how to play and share with others.
☐	☐	My child says positive things about themselves.
☐	☐	My child can tell when others are happy, mad or sad.
☐	☐	My child enjoys pretend play.
☐	☐	My child eats a variety of foods.
☐	☐	My child can sing a song.
☐	☐	My child can hop on one foot.

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
Balances on each foot for 2 seconds	Yes	No	Parent is loving toward child	Yes	No
Says first and last name when asked	Yes	No	Positively talks, listens, and responds to child.	Yes	No
Can draw a person with three parts	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Aggressive or destructive behavior that threatens, harms or damages people, animals or property	Yes	No			
Displays negativity, low self-esteem, or extreme dependence	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: