Address: _____

_____

Name of infant: _____

Name of caregiver: _____

Telephone number: _____

Cellphone number: _____
(Mother/Father/Other)

Health check-up for 1 year and 6 months old

Date of birth: _____ ____ ____ (*YYYYMMDD*)

Birth weight: _____

Gestation period: _____ weeks

Birth order: _____ child (e.g. 1st/2nd)

Caregiver (daytime hours):

Mother / Father / Grandmother / Grandfather / Daycare Center ( ) / Other ( )

Family Structure	Relationship	Age	Employed	Relationship	Age	Employed	Relationship	Age	Employed
			Yes / No			Yes / No			Yes / No
			Yes / No			Yes / No			Yes / No

Please circle ○ your selected answers.

1. Please circle the vaccinations your child has received.

BCG	DPT-IPV				Hepatitis B			Hib				Measles-rubella (Period I)	Varicella (Chicken pox)		Japanese Encephalitis			Other
	1	2	3	Booster	1	2	3	1	2	3	4		1	2	1	2	Booster	Mumps
					Rotavirus			Children's Pneumococcus										
					1	2	3	1	2	3	4							

2. Please answer the following health questions.

1) Has your child suffered from any significant illnesses or injuries in the past? Yes* / No

**For those who answered yes, or whose child is currently receiving medical treatment, please provide details:*

Spasms / Other:

2) Do you have any concerns about your child's eyes or ears? Yes* / No

Yes:*

3) If there are any other health conditions or concerns, please provide details (e.g. how they walk, personality):

3. Please answer the following dietary questions.

1) Are there any concerns with your childs' eating? Yes* / No

Yes:* [ ]

2) Do they have an appetite? Yes* / No / Irregular

3) Can they chew solid foods well? Yes / No

4) Do they have a set time and amount for eating snacks?

① They mostly do not eat snacks

② The time and amount is set (about ( ) times per day / about once per ( ) days)

③ They are given snacks when they want them (contents:)

5) Do they drink anything apart from water and tea? No / Yes*

Yes:* [Milk: ml / Milk formula: ml
Juice / Sports drink / Probiotic drink / Other ( )]

6) Do you feed them with a baby bottle? No / Yes

7) Are they breastfeed? No / Yes

4. Please answer the following daily lifestyle questions.

1) Do you help them brush their teeth? Yes / No

2) Do you have any concerns about their teeth or mouth? No / Yes*

Yes:* [ ]

3) Approximately how often do they have bowel movements? ( ) times / ( ) day(s)

4) Do they sleep well at night? Yes / No (Extremely hard to sleep / They wake up often / They cry at night)

5) Do they have regular habits almost every day? Yes / No

What time do they wake up? ( ) What time do they sleep? ( )

6) Do you limit their time for watching TV/videos? Yes (hours / day) / No

7) Do they have opportunities to play with other children of the same age? Yes / No

8) What kind of playtime activities do they enjoy?

① Indoor: Car / Train / Picture Book / Blocks / Make-believe Games (e.g. Playing House) / Other ( )

② Outdoor: ( ) times / week: Slide / Sandpit / Running around / Other ( )

5. Please answer the following questions about your child's growth. Please circle the number(s) that apply.

1) Can walk by themselves (since years months old)

2) Can climb up stairs with their hands

3) They turn around when their name is called

4) When they cannot see their mother or usual caregiver, they look for them or follow them

5) They hand you what they are holding when you ask for it

6) They watch and imitate adults' gestures (making phonecalls, combing hair)

7) When adults point to or look at something, they look with interest

8) Can point to show they are interested in something

9) Can point to show they want something

10) When shown a picture book and asked "where's doggie?" they can point to it

11) If you give them simple orders like "can you go grab ...?", they can do it

12) Can speak at least three proper words. Please write the words: (from years months old)

( ) ( ) ( ) ( ) ( )

13) Can try using forks and spoons to eat by themselves

14) Can stack more than 3 building blocks

15) Can scribble with a crayon or pencil

16) Can look at the correct parent when you ask "where's (mom/dad?)"

17) They show interest in other children, watch them or walk up to them

18) Can play with adults by rolling a ball

19) Can show their happiness by looking at an adult's eyes

20) Severely sensitive to certain sounds (such as vacuum cleaners, hair dryers) and/or textures

21) They extremely dislike being held or touched

22) They are constantly moving around, seem to always disappear if you let their hand go

6. Please answer the following questions about parenting.

1) Is there somewhere outdoors in the community you can feel free to take your child to? Yes ( ) / No

2) Are there times when you scold your child by hitting them? No / Sometimes / Often / Daily

What situations cause this: ( )

3) Are there times when you find it difficult or tiring to raise your child? No / Sometimes / Often / Daily

What situations cause this: ( )

4) Do you feel stress from the everyday tasks of raising your child? Yes* / No

**Yes:* Do you have ways to relieve this stress? Yes / No

5) Do you have someone close who can listen to you or help you out? Yes* / No

**Yes:* ① Who are they: ( )

② What kind of help do they provide: ( )

7. Please write anything you would like to discuss about health checkups.

(nutrition, dentistry, psychological development)

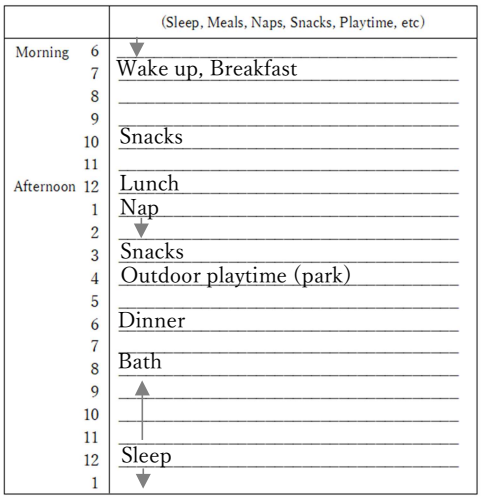
*Please provide details of your questions: ( )

(e.g. crying at night, weaning, thumb sucking, uncontrollable tantrums, too quiet, bites, hits, very shy, speech delay, etc.)

8. Please provide a brief summary of your child's daily routine. Please only fill in the parts that apply.

		(Sleep, Meals, Naps, Snacks, Playtime, etc.)
Morning	6	
	7	
	8	
	9	
	10	
	11	
Afternoon	12	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1	

Example



The following is a survey from the Ministry of Health, Labor and Welfare's Healthy Parenting 21 (2nd phase).
Thank you for your cooperation.

1. 1) Do you (mother) currently smoke? No / Yes (cigarettes per day)
   2) Does your child's father currently smoke? No / Yes (cigarettes per day)
2. Do you brush your child's teeth daily?
   The child's teeth are brushed with help (after they brush their own teeth, the caregiver helps them brush)
   The child's teeth are brushed by the caregiver only
   The child brushes their own teeth
   The caregiver nor the child brushes their teeth
3. 1) Has your child received the DPT-IPV (Diphtheria/Pertussis/Tetanus/Polio) vaccination (Period 1: Initial 3 doses)? Yes / No
   2) Have they been vaccinated to protect against Rubella and Measles? Yes / No
4. Would you like to continue to raise your child in this community?
   Yes, I want to / I think I'd prefer to / I think I'd rather not / No, I dont want to
5. Does your child's father help raise your child?
   Yes, he does / He sometimes does / He doesn't do much / Not sure
6. Are your bathroom doors fitted designed so that children cannot open them on their own?
   Yes / No / Not applicable
7. Do you (mother) feel that you have leisurely time to spend with your child? Yes / No / Its hard to say
8. Do you find it difficult to raise your child? I always do / I sometimes do / I don't find it difficult
   When you find it difficult, do you have ways to receive advice and/or solve these difficulties? Yes / No
9. Do you know that most children between the ages of 18 months and 2 years old try to show they are interested in something by pointing? Yes / No
10. In the past few months, have any of the following things happened in your family? Please circle all that apply.
    Excessive discipline / Child was violently hit / Infant was left home alone / Child was not fed for a long period / Yelled at the child in a strong tone / Shut the child's mouth / The child was shaken violently / None of these apply