Address: _____

_____

Name of infant: _____

Name of caregiver: _____

Telephone number: _____

Cellphone number: _____
(Mother/Father/Other)

Health check-up for 3 years 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( ) / Kindergarten( ) / 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 / Epilepsy / Other:

3. Please answer the following dietary questions.

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

Yes:*

2) Do they have likes and dislikes for food, and/or are a picky eater? No / Yes*

Yes:*

3) Are there times when they skip breakfast? No / Sometimes / Yes

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

5) What kind of snacks do they eat in a day?

(times / day) (type of snacks:)

6) What do they drink apart from water and tea? ( )

7) Have you heard of the term "Nutrition/Dietary Education"? Yes/No

Nutrition/Dietary Education is about growing "The Power of Eating" for each child. This is a way to deepen the relationship between parents, children and families through food, and promote children's healthy mental and physical health.

8)Please circle which of the below you are consciously making an effort to do (multiple answers allowed)

( ) ① Eat three meals a day (breakfast, lunch and dinner) in a consistent manner

( ) ② Incorporate a diverse range foods in a balanced manner

( ) ③ Create ways for your child to get involved with meal preparation and cooking

( ) ④ Eat meals together with someone

( ) ⑤ Discuss food and meal planning often with your child

4. Please answer the following questions about your child's teeth.

1) Does your child brush their teeth? Yes* / No

*Yes**: ① When (After breakfast / After lunch / After dinner / Before bed)

② Do you help them brush their teeth? Yes / No

2) Do they suck their fingers? No / Yes

3) Do you have any concerns about their teeth alignment, bite, or other mouth-related concerns ? No / Yes*

*Yes**: ( )

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

1) Can stand for 2-3 seconds on one foot

2) Can say "this", "that", "me", "I" etc.

3) Can say their name

4) Can draw a circle

5) Can pee by themselves (or when accompanied by caregivers)

6) Can speak two or three phrases (from years months old)

7) Can tell the difference between big and small

8) Can tell the difference between long and short

9) Can tell the difference between colors

10) Can tell apart gender

11) Can use chopsticks or scissors

12) They play make-believe games (e.g. Playing House) that involve interaction

13) They sometimes have difficulty making eye contact when talking or playing

14) There are some concerns regarding conversation (e.g. they repeat phrases from TV shows or ads, have one-sided conversations and do not listen to the other person, etc.)

15) When things don't go how they expect them to, this can cause uncontrollable tantrums (panic attacks)

16) They look at and touches things that are shiny, moving, watery etc. for a long time without getting bored

17) They have a strong knowledge of specific things such as road signs and markings, numbers, letters etc.

18) Can watch a particular scene in a video repeatedly without getting bored

19) They stick to a particular way or method of doing things, which can be hard to handle

20) They often walk on their tiptoes (or used to)

21) There are concerns regarding their sense of hearing, taste and touch (e.g. they are sensitive to certain sounds, block their ears, are an extremely picky eater, are insensitive to pain, do not like having dirty hands, etc.)

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: ( )

(e.g. very shy, doesn't play with friends, restless and constantly moving, crying at night, touches their genitals, stutters (stuck for words, etc.), thumb sucking, nail biting, wets themselves during the day, blinks too much, etc.)

8. Please answer the following daily lifestyle questions.

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

2) Do they sleep well at night? Yes / No

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

4) Do they show interest in and play with other children of the same age? Yes / No

5) 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 ( )

6: Do they have any habits or behaviors that concern you? Yes* / No

*Yes**: ( )

9. 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

		(Sleep, Meals, Naps, Snacks, Playtime, etc)
Morning	6	
	7	Wake up, Breakfast
	8	
	9	
	10	Snacks
	11	
Afternoon	12	Lunch
	1	Nap
	2	
	3	Snacks
	4	Outdoor playtime (park)
	5	
	6	Dinner
	7	
	8	Bath
	9	
	10	
	11	
	12	Sleep
	1	

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. 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
3. Does your child's father help raise your child?
   Yes, he does / He sometimes does / He doesn't do much / Not sure
4. Do you (mother) feel that you have leisurely time to spend with your child? **Yes / No / Its hard to say**
5. 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**
6. Do you know that most children between the ages of 3 to 4 years old will join in if other kids invite them to play?
   Yes / No
7. 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 / None of these apply
8. Does your child have an assigned family doctor? **Yes / No / Not sure**
9. Does your child have an assigned family dentist? **Yes / No / Not sure**

Questionnaire about Vision

1) Please do the following examination on your child using the attached chart. Write a ○ for what they can see, and a X for what they cannot see.

				
Both Eyes				
Right Eye				
Left Eye				

2) If there are any eye concerns please circle (○) the below.

1) I am concerned about the look of their eyes
2) Very sensitive to glare
3) Goes up close to something to look at it
4) Squints their eyes to look
5) Tilts head or looks sideways
6) Other ( )

Are they currently seeing a doctor for eye illness? Yes* / No Name of Illness ( )
*Yes**: Please write the name of your medical institution: ( )

Questionnaire about Hearing

1) Please do the following examination on your child using the attached chart. Write a ○ for what they can hear, and a X for what they cannot hear.

Inu	*Kutsu*	*Kasa*	*Zou*	*Neko*	*Isu*

2) Please circle (○) the answers that apply.

1) Do you have family members or close relatives who have been hard of hearing from a young age? Yes / No
2) Have they had ear inflammations (middle ear) more than once? Yes / No
3) Do they often get a stuffy nose, runny nose, breathe through their mouth, or a hoarse throat? Yes / No
4) Are there times when you think they cannot hear well, such as not answering you when you call them, asking you to repeat what you said, or turning the TV volume up loud? Yes / No
5) Has anyone close to you and your child noticed that your child cannot hear well? Yes / No
6) Do you have any concerns about their way of talking, such as delayed speech or problems with pronunciation? Yes / No
7) Are there times when the meaning of words cannot be conveyed to your child without adding gestures/actions? Yes / No
8) Are they currently seeing a doctor for ear or nose illnesses? Yes* / No Name of Illness ( )
*Yes**: Please write the name of your medical institution: ( )