Patient Name_____ Date of Birth_____

Young Child with IDD Health Check

- Use this form to check concerns you want to share with your clinician.
  - If you check many, please circle the two most important for today.

General

- ☐ Recent life crisis
- ☐ New move or family member change
- ☐ Change in routine – out of daycare, etc.
- ☐ Childcare or school concerns
- ☐ Unsafe at home or in car
- ☐ Can't get to sleep
- ☐ Can't stay asleep
- ☐ Falling asleep in day
- ☐ Lost weight
- ☐ Not gaining weight or growing well
- ☐ Puberty concerns

Head

- ☐ Rub eyes, doesn't focus with eyes
- ☐ Rub ears, doesn't seem to listen
- ☐ Snoring
- ☐ Won't brush teeth
- ☐ Teeth pain, teeth grinding, gums bleed

Chest

- ☐ Chest pain – grab or rub chest
- ☐ Short of breath
- ☐ Cough or wheezing
- ☐ Tire out during activity
- ☐ Fall or sit during activity
- ☐ Get very sweaty, blotchy or clammy
- ☐ Heart pounds
- ☐ Pass out or seems dizzy

Belly

- ☐ Belly pain – hold or rub belly
- ☐ Eat only a few types of food
- ☐ Eat too little
- ☐ Eat too much
- ☐ Eat too fast, not chewing
- ☐ Drink too little
- ☐ Choke or throat clearing
- ☐ Swollen belly, gassy
- ☐ Sick stomach or vomiting
- ☐ Watery poop
- ☐ Hard or large poop
- ☐ Poop less often than every 2 days
- ☐ Too little urine, holds urine long
- ☐ Too frequent urine
- ☐ Toilet training concern

Skin, Muscles and Joints

- ☐ Rashes or itching
- ☐ Dry skin, cracks or peeling
- ☐ Red or purple spots from pressure
- ☐ Bruises or skin color changes
- ☐ Nail or hair problems
- ☐ Picking skin
- ☐ Trouble bathing or dressing
- ☐ Unusual leg/arm shape, turn in or out
- ☐ Swelling in feet, legs, joints

Brain

- ☐ Headaches – hold, rub, or bang head
- ☐ Odd movements, twitching, jerking
- ☐ Staring spells
- ☐ Movement slow, stiff, wobbly

Mood & Development

- ☐ Excess fears or anger
- ☐ Withdraw from others
- ☐ Not enjoying play
- ☐ Too much screen time
- ☐ Not using words
- ☐ Not paying attention or focusing
- ☐ Having meltdowns
- ☐ Hurts self or others
- ☐ Running away