1.5-Year-Old Health Checkup Qustionnaire

Please fill out this form and bring it with you on the day of the checkup.

Checkup Date (YYYY/MM/DD) / / Registration Number:

※Eligibility:Must be a registered resident of Fujisawa City on the day of the checkup.

This form should be completed by the child's primary caregiver.

Your Relationship to Child

Father / Mother / Grandfather / Grandmother / Others ( )

Write in Katakana, if possible. **Male / Female**

Child's Name

Child's Birthdate (YYYY/MM/DD) **Child's Age (Today)** **Birth Order:[ ]**

/ / Months Old

Address *Please fill this in ONLY IF your current address is different from your mailing address.

City of Fujisawa

Phone Number

NOTE: The information provided may be shared with the Child and Family Center if deemed necessary by the City.

Parent/Guardian Name	Relationship	**Parent/Guardian Name**	Relationship

Family Members:( ) people in total *Please circle the members below.

Father Age: Occupation:

Mother Age: Occupation:

Siblings: Older brother, Older sister, Younger brother, Younger sister

Grandfather Grandmother Other ( )

Daytime Caregiver

Father / Mother / Nursery school ( ) / Grandfather / Grandmother / Other ( )

Course of Pregnancy

Abnormality: None /Yes ( )

Condition at Delivery

Abnormality: None /Yes ( )

Condition at Birth

Weeks of Pregnancy:[ ] weeks

Abnormality: None /Yes ( )

Birth weight: g

Birth length: cm

Developmental Milestones

Holding head steady [ ] months

Rolling over [ ] months

Sitting up [ ] months

Crawling [ ] months

Walking [ ] months

Vaccination Record (Please circle all that apply.)

Pediatric pneumococcal: 1st / 2nd / 3rd / Booster

Hepatitis B: 1st / 2nd / 3rd **Rotavirus**:( ) times **BCG**

5(4)- in- 1 vaccine (DTP-IPV-Hib combination vaccine):I- 1st / 2nd / 3rd / Booster

MR (Measles-Rubella) **Chickenpox**: 1st / 2nd **Other** ( )

About your child's health and safty

For Office Use Only

1 Does your child have any medical conditions present from birth? No / Yes (Condition: , Medical Institution:)

2 Has your child ever taken to a hospital for an accidental injury? No / Yes (Falls / Falls from height / Accidental ingestion / Drowning / Traffic accidents / Other (

3 Have you taken safety measures in accordance with the child's growth, e.g. preventing them from getting out on the balcony or entering the bathroom alone? Yes / No

4 Does your child often get very upset or throw a tantrum? No / Yes

5 Have you ever felt your child is too quiet (e.g. not crying or not moving much)? No / Yes

6 Has your child ever had seizures or convulsions? No / Yes

7 Has your child ever been diagnosed with asthma or atopic dermatitis? No / Yes

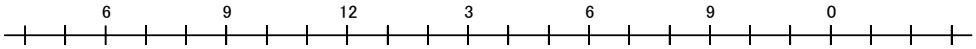
■健診履歴
1
4
9~10

■感染症
あり ・ なし

About your child's daily life

1 Please describe your child's daily routine on the timeline below:

e.g.,waking up, bedtime, meals, naps, snacks, daycare/nursery, playtime, walks, park time, TV/screen time, bathtime.



2 Does the child have more than two hours of screen time a day? (e.g., TV, tablets, smartphones etc.) No / Yes ( ) hours a day

3 How often does your child have bowel movements? ( ) times a day

4 Does your child try to take their jacket off? Yes / No

5 Do you finish brushing your child's teeth every day? Yes / No

6 ① Are you currently breastfeeding? No / Yes : When? Before bed / At night / On demand / Other:( )

② Does your child still use a bottle? No / Yes : When? Before bed / At night / On demand / Other:( )

7 Do you have any concerns about your child's eating habit, such as picky eating or small appetite? No / Yes ( )

8 What snacks does your child usually have? ( )

9 Does your child frequently drink sugary beverages like juice, sports drinks, or lactic acid drinks? No / Yes

市記入欄 Office use only	父 ・ 母 ・ その他( )	保健師サイン

Please turn over ↓

About your child's development		For Office Use Only
1	Can your child climb the stairs when you are holding their hands?	Yes / No
2	Have you noticed any stiffness or awkwardness in your child's leg or arm movements?	No / Yes
3	Does your child hold pencils and scribble?	Yes / No
4	Does your child eat with a spoon by themselves?	Yes / No
5	Is your child okay when you cover one eye at a time while looking at something?	Yes / No
6	Does your child point to familiar objects in a picture book?	Yes / No
7	Does your child imitate the gestures of people around them?	Yes / No
8	Does your child try to show you by pointing something they are interested in?	Yes / No
9	Does your child say actual words, such as "papa", "mama" or "car"?	Yes (example:) / No
10	Does your child show interests in people or other children around them?	Yes / No
11	Does your child play with toys they like?	Yes / No
12	Does your child respond with pleasure when you play together?	Yes / No
13	Does your child understand simple words, such as "Come here", "Bedtime" or "Give me"?	Yes / No

About yourself		
1	How do you feel about parenting?	Enjoyable / Challenging but enjoyable / Often frustrated / Often overwhelmed or unsure what to do
2	How do you rate your recent physical and mental health?	Good / Fairly good / Average/ Not so good / Poor
3	Do you have someone or an organization to go for support with parenting?	Yes(Please specify:)/ No
4	Do you have information about local parenting groups or parenting support organizations?	Yes / No
5	How do you feel about your current financial circumstances?	Very comfortable / Comfortable / Average / Difficult / Very difficult
6	Are you currently concerned about any of the following?	Your child / Your spouse or partner / Your parents or in-laws / Friends or other parents / Other ( )

Please feel free to write any questions or concerns

Questionnaire based on Basic Policy on Child and Maternal Health and Development

This questionnaire is a survey to help create a healthy environment for children's growth, based on national policy guidelines. Survey results will be anonymized and converted into statistical data for reporting to the national government. Your personal information wil be strictly protected.

1	Does the child's mother currently smoke? (Including e-cigarettes and heat-not-burn tobacco)	No / Yes (cigaretts a day)
2	Does the child's father or partner currently smoke? (Including e-cigarettes and heat-not-burn tobacco)	No / Yes (cigaretts a day)
3	To those ansewed "Yes" for questions 1 and/or 2, do you want to quit smoking?	Yes (mother / father / partner) / No
4	Do you finish brushing your child's teeth everyday?	I finish after my child brushes./ Only I brush./ Only my child brushes./ Neither of us brushes.
5	Do you want to continue to raise your child in this community?	Yes,definitely / Somewhat yes / Not really / No, not at all
6	Do you and your spouse/partner share household chores and parenting?	Yes,definitely / Somewhat yes / Not really / No, not at all
7	Do you have time to relax and enjoy spending with your child?	Yes / No / Not sure
8	Do you find it difficult to raise your child?	Never / Sometimes / Always
9	(For those who answered "Sometimes" and "Always" for Question No.8) Do you know how to get support or find a solution when you experience difficulty with parenting ?	Yes / No
10	Have any of the following occurred in your household in the past few months? Please circle all that apply :	Disciplining too harshly, Hitting or slapping the child emotionally, Leaving the child home alone, Shaking the child violently, Not feeding the child for a long period, Yelling at the child with harsh words, Covering the child's mouth with hands, None of the above