Bright Futures Parent Supplemental Questionnaire 12 Month Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please circle Yes or No for each question. Thank you.

Family Support

Do you need help teaching your child good behavior?	No	Yes
Do you reward your child's good behavior?	Yes	No
When your child misbehaves, do you use brief time-outs (1–2 minutes)?	Yes	No
Do you try to distract your child when she misbehaves?	Yes	No
Do you discuss your ideas about your child's behavior and discipline with your child's caregivers?	Yes	No
Do you participate in activities through social, religious, volunteer, or recreational programs?	Yes	No
Do you talk with friends about parenting?	Yes	No
Do you go to playgroups?	Yes	No

Establishing Routines

Do you play with and read to your child every day?	Yes	No
Do you help your child feel comfortable around new people?	Yes	No
Does your child have regular mealtimes and snack times?	Yes	No
Do you have a regular bedtime routine for your child?	Yes	No
Does your child play actively for one hour or more a day?	Yes	No
How many hours per day does your child watch TV?	_____ hours	

Feeding Your Child: Feeding and Appetite Changes

Do you give your child small, hard foods like peanuts or popcorn?	No	Yes
Do you give your child round foods such as hot dogs, raw carrots, or grapes?	No	Yes
Does your child try feeding himself using a spoon or fork?	Yes	No
Do you let your child decide what and how much to eat?	Yes	No

Finding a Dentist: Establishing a Dental Home

Have you taken your child to a dentist?	Yes	No
Do you brush your child's teeth with water 2 times a day, using a soft toothbrush?	Yes	No
Does your child use a bottle?	No	Yes

Safety

Do you always use a car safety seat rear-facing in the back seat of all vehicles?		Yes	No
Are you having any problems with your car safety seat?		No	Yes
Do you know when to turn your child's car safety seat forward?		Yes	No
Do you keep cleaners and medicines locked up?		Yes	No
Do you have a gate on your stairs?		Yes	No
Are you able to lock your windows?		Yes	No
Can your child climb out of her crib?		No	Yes
Is your child's crib on the lowest setting?		Yes	No
Do you stay within arm's reach when your child is in the bathtub?		Yes	No
Do you have a swimming pool, pond, or lake in or near your home?		No	Yes
Does anyone in your home or the homes where your child spends time have a gun?		No	Yes
If so, are the guns unloaded and locked away?	N/A	Yes	No
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to stop?		Yes	No