

Child's health and wellbeing

Are you concerned about your child's health? <input type="checkbox"/> No <input type="checkbox"/> Yes, why? _____	
Does your child have any long-term symptoms, illnesses or injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify _____	
Does your child continuously or occasionally use any medicines? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify _____	
Does your child have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify _____	
Does your child have a special diet? <input type="checkbox"/> No <input type="checkbox"/> Yes, which of the following?	
<input type="checkbox"/> lactose-free or low-lactose diet	<input type="checkbox"/> grain allergy diet
<input type="checkbox"/> gluten-free diet	<input type="checkbox"/> milk allergy diet
<input type="checkbox"/> vegetarian diet including dairy products and/or eggs	<input type="checkbox"/> other diet due to a food allergy
<input type="checkbox"/> vegetarian diet including fish	<input type="checkbox"/> other special diet
<input type="checkbox"/> vegan diet	
If your child has a diagnosed illness, where is their illness treated? _____	
Has your child repeatedly had any of the following symptoms?	
<input type="checkbox"/> abdominal problems/constipation	<input type="checkbox"/> prolonged head cold (more than 2 months)
<input type="checkbox"/> skin rash	<input type="checkbox"/> other symptoms, ailments or pains
<input type="checkbox"/> prolonged cough (more than 2 months)	
Has your child been in an accident requiring a visit to a physician, public health nurse or nurse? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify _____	
Do you think your home is safe for children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you think the area surrounding your home is safe for children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind of potential safety risks have you identified in your child's living environment? _____	
Please describe your child's nature _____	
Have you noticed any behaviour that worries you? <input type="checkbox"/> No <input type="checkbox"/> If yes, what? _____	

Parent's/guardian's opinion on the child's development

Does your child like to walk, run or jump cheerfully? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child like to play different games? <input type="checkbox"/> Yes <input type="checkbox"/> No
What kind of games does your child play and with whom? _____	
Is your child's speech clear and understandable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you read books with your child? <input type="checkbox"/> Yes <input type="checkbox"/> No

Does your child like drawing and crafts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child eat different types of food independently? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child made friends with other children? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can your child take other children into consideration well? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child recognise the need to go to the toilet on their own? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child wet the bed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any illnesses, developmental delays or learning difficulties in your family (parents, grandparents, biological siblings)? <input type="checkbox"/> No <input type="checkbox"/> Yes, which and who has them? _____	

The child and the family's health habits

My child's sleep pattern suits our family's everyday life <input type="checkbox"/> Yes <input type="checkbox"/> No	My child usually sleeps the entire night without waking up <input type="checkbox"/> Yes <input type="checkbox"/> No
My child usually falls asleep easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child take naps? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does anything related to how your child sleeps make your family's everyday life harder? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify _____	
How many hours does your child spend outdoors every day? _____	
Special observations on your child's physical activity and outdoor activities _____	
Our family engages in physical activity <input type="checkbox"/> daily <input type="checkbox"/> less often than weekly <input type="checkbox"/> a few times per week <input type="checkbox"/> never	

Child's meals and diet

[National nutrition recommendations](#)

My child generally eats <input type="checkbox"/> breakfast <input type="checkbox"/> dinner <input type="checkbox"/> lunch <input type="checkbox"/> evening snack <input type="checkbox"/> afternoon snack	
Does your child have snacks every day? <input type="checkbox"/> No <input type="checkbox"/> Yes, what do they snack on? _____	
Your child's diet includes <input type="checkbox"/> milk and/or dairy products <input type="checkbox"/> meat <input type="checkbox"/> vegetables, fruit and berries <input type="checkbox"/> fish	
Does your child get a vitamin D supplement <input type="checkbox"/> daily <input type="checkbox"/> never <input type="checkbox"/> sometimes	
If you wish, you can tell us more about their diet and eating habits. 	

Family diet

Our family's diet is
<input type="checkbox"/> omnivorous diet <input type="checkbox"/> vegetarian diet
<input type="checkbox"/> other diet _____
Does your family eat together?
What is good about your family's eating habits?
What about your family's eating habits should be improved?

Child's oral health

My child's teeth are brushed
<input type="checkbox"/> twice a day or more often <input type="checkbox"/> less than once a day
<input type="checkbox"/> once a day <input type="checkbox"/> never
Do you brush your child's teeth with fluoride toothpaste?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child use xylitol products?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child had an oral health examination in the past year?
<input type="checkbox"/> Yes <input type="checkbox"/> No

Media usage

The Small children and screen time recommendation (in Finnish)

If your child spends time looking at a screen (smartphone, computer, gaming consoles, TV, etc.) every day, in what situations does this happen?
<input type="checkbox"/> while eating <input type="checkbox"/> as a reward for something
<input type="checkbox"/> when calming down <input type="checkbox"/> other, please specify

If your child spends time looking at a screen every day, how much time per day (please estimate)?

Tobacco and substance use by adults in the family

Substance screening form for maternity and child health clinics

Use of nicotine products: summary of what, how many per day?
Alcohol: AUDIT score (both/all parents)
Drugs and medicines: summary what, how much?
Is your child exposed to tobacco smoke?
<input type="checkbox"/> daily <input type="checkbox"/> sometimes <input type="checkbox"/> never

Information on the family's wellbeing

Does your family spend enough time together?

Yes No

How does your family spend time together?

Our family

- | | |
|---|--|
| <input type="checkbox"/> tends to give encouragement and positive feedback | <input type="checkbox"/> reconciles conflicts |
| <input type="checkbox"/> shares household chores | <input type="checkbox"/> tends to share what has happened during the day |
| <input type="checkbox"/> makes everyone feel safe, and usually the atmosphere is peaceful | <input type="checkbox"/> has agreed on rules together |
| <input type="checkbox"/> puts feeling into words | |

Do you feel that you need help in matters related to the upbringing of your child or everyday life in the family?

- yes, what kind of help? _____
- no
- we already receive help, from whom and what kind of help? _____
- we have received help in the past, from whom and what kind of help? _____

Family concerns or issues taking up resources that affect your child's wellbeing

Our family faces the following

- | | |
|--|---|
| <input type="checkbox"/> long-term illnesses (physical/mental) | <input type="checkbox"/> financial worries |
| <input type="checkbox"/> difficulty coping, exhaustion or depression | <input type="checkbox"/> grief or loss |
| <input type="checkbox"/> insecurity or violence | <input type="checkbox"/> other topical issues |
| <input type="checkbox"/> substance abuse problems or addiction | <input type="checkbox"/> none of the above |

If you wish, you may tell us more

Who can provide support for your family's everyday life if necessary?

- | | |
|--|----------------------------------|
| <input type="checkbox"/> grandparents | <input type="checkbox"/> friends |
| <input type="checkbox"/> former spouse | <input type="checkbox"/> others |
| <input type="checkbox"/> neighbours | <input type="checkbox"/> no one |

If you wish, you may tell us more

What about your child delights you?

What are your family's strengths?

Do you have any wishes for the health examination?

The following persons have participated in filling in the form