

12 Month Well Child Check

Name: _____

Date: _____

Diet:

Has baby been weaned from the bottle or breast? _____

Does baby still use pacifier? _____

Have you introduced cow's milk? _____

Does baby take a multivitamin with fluoride? _____

Does baby get 3 meals a day? _____

Does baby eat 2-3 healthy snacks a day? _____

Dental:

Does baby have any teeth? _____ if yes how many? _____

Do you use plain water to rinse teeth twice daily? _____

Is there staining on child's teeth? _____

Do they sleep with a bottle or breastfeed during the night? _____

Elimination:

How many wet diapers a day? _____

How many stool diapers a day? _____

Sleep:

Is baby sleeping for 12-14 a day? _____

Does baby have a routine bedtime? _____

Does baby take 1 nap a day? _____

Behavior/Temperament

Do you have any concerns?

Does child get consistent discipline? _____

What is the method of discipline? _____

Development:

Do you have any concerns about your child's development, behavior, or learning? yes no

If yes, please describe:

Babies at 12 months almost all will (please circle yes or not)

- wave bye bye yes no
- indicate wants yes no
- play pat a cake yes no
- dada mama specific yes no
- jabbers yes no
- stand for 2 seconds yes no
- play with parent yes no
- points yes no
- grasp things with thumb and first finger yes no

Some children can

- walk well yes no
- stoop and recover yes no
- stand alone yes no
- 1-3 words yes no
- put block in cup yes no
- scribbles yes no
- drink from cup yes no
- imitate activities yes no

Social:

Any changes at home or new stressors? _____



Ages & Stages Questionnaires®

12 Month Questionnaire

11 months 0 days through 12 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____ Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION



	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," <i>without</i> your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When your baby wants something, does he tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
			COMMUNICATION TOTAL	___

GROSS MOTOR



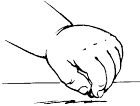

	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby stand up in the middle of the floor by himself and take several steps forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
	GROSS MOTOR TOTAL			

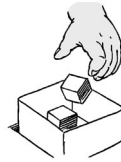
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ *
				
5. Does your baby throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
	FINE MOTOR TOTAL			

*If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|------|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? <i>(Be sure the toy is completely hidden.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? <i>(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? <i>(You may show him how to do it.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___* |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? <i>(If she already scribbles on her own, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



PROBLEM SOLVING TOTAL

**If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."*

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? <i>(If he already lets go of the toy into your hand, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PERSONAL-SOCIAL TOTAL

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. Does your baby play with sounds or seem to make words? If no, explain:

YES

NO

3. When your baby is standing, are her feet flat on the surface most of the time?
If no, explain:

YES

NO

4. Do you have concerns that your baby is too quiet or does not make sounds like
other babies do? If yes, explain:

YES

NO

5. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

YES

NO

OVERALL (continued)

6. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

7. Has your baby had any medical problems in the last several months? If yes, explain:

 YES NO

8. Do you have any concerns about your baby's behavior? If yes, explain:

 YES NO

9. Does anything about your baby worry you? If yes, explain:

 YES NO



12 Month ASQ-3 Information Summary

11 months 0 days through
12 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	15.64		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	21.49		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	34.50		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	27.32		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	21.73		●	●	●	●	○	○	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | |
|--|---------------|--|---------------|
| 1. Uses both hands and both legs equally well?
Comments: | Yes NO | 6. Concerns about vision?
Comments: | YES No |
| 2. Plays with sounds or seems to make words?
Comments: | Yes NO | 7. Any medical problems?
Comments: | YES No |
| 3. Feet are flat on the surface most of the time?
Comments: | Yes NO | 8. Concerns about behavior?
Comments: | YES No |
| 4. Concerns about not making sounds?
Comments: | YES No | 9. Other concerns?
Comments: | YES No |
| 5. Family history of hearing impairment?
Comments: | YES No | | |

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

Risk Indicators for Hearing Loss Checklist

(To be used with the **Developmental Scales** form when performing KBH screens for birth through four years of age.)

Child's name: _____ Birthdate: _____

What was your child's birth weight? _____ Premature? _____ By how many weeks? _____

Was the child's hearing screened as a newborn? Yes ___ No ___ Unknown ___

Results of the testing/screening: _____

Has your child's hearing been tested or screened since birth? Yes ___ No ___ Unknown ___

Results of the testing/screening: _____

Directions: Mark an X in the appropriate column. If an indicator exists but has been referred in a previous screening, note to whom the child was referred and note the follow-up recommendations.

{N = indicator for infants birth through 28 days old who *did not* have newborn hearing screening; for children older than 28 days, answer all questions.}

YES NO

___ ___ 1. Do you have a concern about your child's hearing, speech, language or other development delay?
List concerns: _____

___ ___ 2. **N** As a newborn, did your child have an illness/condition requiring 48 hours or more in the NICU?
Explain: _____

___ ___ 3. **N** Was your child exposed to any of the following during the mother's pregnancy? Check all that apply:
toxoplasmosis syphilis rubella cytomegalovirus herpes unknown

___ ___ 4. **N** Does your child have any abnormal features of the outer ear, ear canal, mouth, nose, neck or head?
Explain: _____

___ ___ 5. **N** Have any of your child's relatives had a permanent hearing loss before the age of 5?
Explain: _____

___ ___ 6. **N** Was your child diagnosed at birth as having a syndrome or condition known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction?
Explain: _____

___ ___ 7. Has your child been diagnosed as having any syndromes associated with progressive hearing loss such as Down, Usher, Waardenburg; a neurodegenerative disorder such as Hunter syndrome; or sensory motor neuropathies such as Friedreich's ataxia or Charcot-Maire-Tooth Syndrome?
Explain: _____

___ ___ 8. Has your child had bacterial meningitis (or other postnatal infections) associated with hearing loss?
If yes, at what age? _____ Hearing testing since then? _____

___ ___ 9. Has child ever had any head trauma?
Explain: _____

___ ___ 10. As a newborn, did your child need an exchange transfusion because of hyperbilirubinemia, or have the need for mechanical ventilation, or conditions requiring ECMO?
Explain: _____

___ ___ 11. Has your child had otitis media with effusion that lasts for more than 3 months? Yes ___ No ___
If yes, were tubes placed? Yes ___ No ___ If yes, when? _____ Are they in place now? Yes ___ No ___

Note: The presence of any risk indicator denotes need for screening every six months up to three years of age or as otherwise indicated by an audiologist.

Pass = All "NO" responses. Refer = One or more "YES" response(s). **Check One: Pass** **Refer**

If other, explain: _____

Screener: _____ **Date:** _____

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.

Developmental Scales

(To be used with **Risk Indicators for Hearing Loss Checklist** when performing KBH screens for birth through four years of age.)

Name: _____ **Date of birth:** _____

Child's chronological age _____ Premature _____ months Adjusted age _____

Does your child: (Please check questions in the appropriate age category – **use adjusted age**)

Birth to 4 months	Yes	No	Yes	No
Startle or cry to loud noises?			Respond to a familiar voice?	
Awaken to loud sounds?			Stop crying when talked to?	
Stop moving when a new sound is made?				

4 to 8 months	Yes	No	Yes	No
Stir or awaken when sleeping quietly and someone talks or makes a loud noise?			Cry when exposed to a sudden or loud sound?	
Try to turn head toward an interesting sound or when name is called?			Make several different babbling sounds?	
Listen to a soft musical toy, bell, or rattle?				

8 to 12 months	Yes	No	Yes	No
Respond in some way to the direction "no"?			Stir or awaken when sleeping quietly and someone talks or makes a loud sound?	
React to name when called?			Try to imitate you if you make familiar sounds?	
Turn head toward the side where a sound is coming from?			Use variety of different consonants and vowels when babbling (cononical babbling*)?	

12 to 18 months	Yes	No	Yes	No
Say "mama" or "dada" and imitate many words you say?			Turn head to look in the direction where the sound came from when an interesting sound is presented?	
Respond to requests such as "come here" and "do you want more"?			Wake up when there is a loud sound?	

18 to 24 months	Yes	No	Yes	No
Try to sing?			Speak at least 20 words?	
Point to several different body parts?			Request by name items such as milk or cookies?	
Respond to simple commands such as "put the ball in the box"?				

2 to 5 years	Yes	No	Yes	No
Point to a picture if you say "Where's the _____"?			Listen to TV or radio at same loudness level as other family members?	
Talk in short sentences?			Hear you when you call child's name from another room?	
Notice most sounds?				

(*Cononical babbling is defined as nonrepetitive babbling using several consonant and vowel combinations, such as "itika," "dabata," "omada." It is quite different from common babbling such as "dada," "mama," or "baba.")

Pass = All "YES" responses or only one "NO" response. Refer = Two or more "NO" responses.

Check one: Pass Refer If other, explain: _____

Screener: _____ **Date:** _____

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.



KBH - EPSDT Blood Lead Screening Questionnaire

To be completed at each KBH screen from 6 to 72 months

Does your child: (circle response received)	DATE: (MM/DD/YYYY)						
1) Live in or visit a house or apartment built before 1960? This could include a day care center, preschool, or the home of a babysitter or relative.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
2) Live in or regularly visit a house or apartment built before 1960 with previous, ongoing, or planned renovation or remodeling?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3) Have a family member with an elevated blood lead level?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
4) Interact with an adult whose job or hobby involves exposure to lead? Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
5) Live near a lead smelter, battery plant, or other lead industry? Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
6) Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
One positive response to the above questions <u>requires</u> a blood lead level test. Remember blood lead levels tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Interviewing staff initials							

Staff signature

Patient name: _____ **ID number:** _____

It is recommended at 12 months for your child to have a CBC and Lead level checked.
We can order these during this visit today.

_____ I consent to labs for my child.

_____ I decline labs for my child.

Parent Signature

Date