14 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 14 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? _____

ASQ-3 Ages & Stages Questionnaires®

13 months 0 days through 14 months 30 days

14 Month Questionnaire

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: _____

P101140100

14 Month Questionnaire

13 months 0 days through 14 months 30 days

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:

_____

_____

_____

_____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your baby more than one time. If possible, try the activities when your baby is cooperative. If your baby can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. 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.)*	◯	◯	◯	___
2. When your baby wants something, does she tell you by *pointing* to it?	◯	◯	◯	___
3. Does your baby shake his head when he means "no" or "yes"?	◯	◯	◯	___
4. Does your baby point to, pat, or try to pick up pictures in a book?	◯	◯	◯	___
5. Does your baby say four or more words in addition to "Mama" and "Dada"?	◯	◯	◯	___
6. When you ask her to, does your baby go into another room to find a familiar toy or object? *(You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")*	◯	◯	◯	___
			COMMUNICATION TOTAL	___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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.)* 	◯	◯	◯	___
2. When you hold *one hand* just to balance her, does your baby take several steps forward? *(If your baby already walks alone, mark "yes" for this item.)* 	◯	◯	◯	___

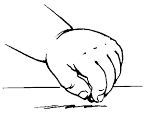
E101140200

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
3. Does your baby stand up in the middle of the floor by himself and take several steps forward?	◯	◯	◯	___
4. Does your baby climb onto furniture or other large objects, such as large climbing blocks?	◯	◯	◯	___
5. Does your baby bend over or squat to pick up an object from the floor and then stand up again without any support?	◯	◯	◯	___
6. Does your baby move around by walking, rather than by crawling on his hands and knees?	◯	◯	◯	___

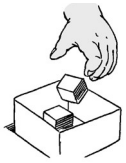
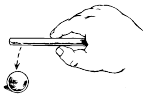
GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. 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? 	◯	◯	◯	___
2. Does your baby throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	◯	◯	◯	___
3. Does your baby help turn the pages of a book? *(You may lift a page for her to grasp.)*	◯	◯	◯	___
4. Does your baby stack a small block or toy on top of another one? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	◯	◯	◯	___
5. Does your baby make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	◯	◯	◯	___
6. Does your baby stack three small blocks or toys on top of each other by herself?	◯	◯	◯	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although he may not let go of it? *(If he already lets go of the toy into a bowl or box, mark "yes" for this item.)*	◯	◯	◯	___
2. Does your baby drop two small toys, one after the other, into a container like a bowl or box? *(You may show her how to do it.)* 	◯	◯	◯	___ *
3. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? *(If he already scribbles on his own, mark "yes" for this item.)*	◯	◯	◯	___
4. Can your baby drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?	◯	◯	◯	___
5. Does your baby drop several small toys, one after another, into a container like a bowl or box? *(You may show her how to do it.)*	◯	◯	◯	___
6. After you have shown your baby how, does he try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? 	◯	◯	◯	___

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 2 is marked "yes" or "sometimes," mark Problem Solving Item 1 as "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg?	◯	◯	◯	___
2. Does your baby roll or throw a ball back to you so that you can return it to him?	◯	◯	◯	___
3. Does your baby play with a doll or stuffed animal by hugging it?	◯	◯	◯	___
4. Does your baby feed herself with a spoon, even though she may spill some food?	◯	◯	◯	___
5. Does your baby help undress himself by taking off clothes like socks, hat, shoes, or mittens?	◯	◯	◯	___
6. Does your baby get your attention or try to show you something by pulling on your hand or clothes?	◯	◯	◯	___

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

14 Month ASQ-3 Information Summary

13 months 0 days through 14 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	17.40		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	25.80		●	●	●	●	●	●	○	○	○	○	○	○	○
Fine Motor	23.06		●	●	●	●	●	○	○	○	○	○	○	○	○
Problem Solving	22.56		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	23.18		●	●	●	●	●	○	○	○	○	○	○	○	○

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

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						

P101140700

Revised 04.2016

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.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)

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.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)

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**
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**
3) **Have a family member with an elevated blood lead level?**		**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**
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**
6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?**		**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**
Interviewing staff initials							

Staff signature

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

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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 (if not already done at 12 months).

_____ I consent to labs for my child.

_____ I decline labs for my child.

_____ _____

Parent Signature Date