

18 Month Well Child Check

Name: _____

Date: _____

Diet:

Is child weaned off bottle and pacifier? _____

Is child weaned from breast? _____

Does child get a variety of solid foods? _____

Does child drink at least 20 ounces of milk per day? _____

Is child offered water instead of juice? _____

Dental:

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

Have you had fluoride treatments done? _____

Do you use plain water to brush 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 your child sleeping for 12-14 at night? _____

How many naps taken in a day? _____

Behavior/Temperament

Do you have any concerns?

Development:

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

If yes, please describe:

Children at 18 months almost all will (please circle yes or no)

- use spoon or fork yes no
- help in the house yes no
- make tower of 2 cubes yes no
- use 3 words yes no
- runs yes no
- drinks from cup yes no
- understands simple commands yes no
- points to 1-2 body parts yes no
- gives affection yes no

Some children can

- feed doll yes no
- remove clothes yes no
- kick ball forward yes no
- walk up steps yes no
- throw ball overhead yes no
- tower of 4 cubes yes no

Social:

Any changes at home or new stressors? _____



Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 months 30 days



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

Date ASQ completed: _____

Child's information

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

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

Person filling out questionnaire

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

Street address: _____ Relationship to child: 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

| | |
|---------------|--|
| Child ID #: | Age at administration in months and days: |
| Program ID #: | If premature, adjusted age in months and days: |
| Program name: | |



18 Month Questionnaire

17 months 0 days
through 18 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 child.
- Make sure your child 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 child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION


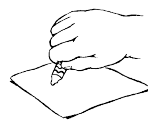
| | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. When your child wants something, does she tell you by <i>pointing</i> to it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. When you ask your child to, does he go into another room to find a familiar toy or object? (<i>You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket."</i>) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Does your child say eight or more words in addition to "Mama" and "Dada"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (<i>Mark "yes" even if her words are difficult to understand.</i>) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (<i>He needs to identify only one picture correctly.</i>) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (<i>Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?"</i>) Please give an example of your child's word combinations: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

COMMUNICATION TOTAL _____

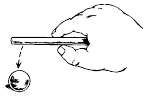
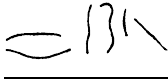

GROSS MOTOR

| | YES | SOMETIMES | NOT YET | _____ |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Does your child move around by walking, rather than by crawling on her hands and knees? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Does your child walk well and seldom fall? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. <i>(You can look for this at a store, on a playground, or at home.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? <i>(If your child already kicks a ball, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
|  | | | | |
| GROSS MOTOR TOTAL | | | | _____ |

FINE MOTOR

| | YES | SOMETIMES | NOT YET | _____ |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. Does your child throw a small ball with a forward arm motion? <i>(If he simply drops the ball, mark "not yet" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
|  | | | | |
| 2. Does your child stack a small block or toy on top of another one? <i>(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
|  | | | | |
| 4. Does your child stack three small blocks or toys on top of each other by himself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Does your child turn the pages of a book by himself? <i>(He may turn more than one page at a time.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| FINE MOTOR TOTAL | | | | _____ |

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|------|
| 1. Does your child drop several small toys, one after another, 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"/> | ___ |
| 2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
|  | | | | |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? <i>(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in <i>any direction</i> ? <i>(Mark "not yet" if your child scribbles back and forth.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div> | | | | |
| 6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? <i>(Do not show him how.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___* |

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. While looking at herself in the mirror, does your child offer a toy to her own image? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <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. Do you think your child hears well? If no, explain:

YES

NO

2. Do you think your child talks like other toddlers his age? If no, explain:

YES

NO

3. Can you understand most of what your child says? If no, explain:

YES

NO

4. Do you think your child walks, runs, and climbs like other toddlers her age?
If no, explain:

YES

NO

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

YES

NO

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

YES

NO

OVERALL (continued)

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

 YES NO

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

 YES NO

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

 YES NO



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child'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 | 13.06 | | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Gross Motor | 37.38 | | ● | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ |
| Fine Motor | 34.32 | | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Problem Solving | 25.74 | | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Personal-Social | 27.19 | | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Hears well? Comments: | Yes | NO | 6. Concerns about vision? Comments: | YES | No |
| 2. Talks like other toddlers his age? Comments: | Yes | NO | 7. Any medical problems? Comments: | YES | No |
| 3. Understand most of what your child says? Comments: | Yes | NO | 8. Concerns about behavior? Comments: | YES | No |
| 4. Walks, runs, and climbs like other toddlers? 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 child's total score is in the area, it is above the cutoff, and the child's development appears to be on schedule.
 If the child's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the child'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:** _____