20 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 20 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? _____

ASQ-3 Ages & Stages Questionnaires®

19 months 0 days through 20 months 30 days

20 Month Questionnaire

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: _____

P101200100

20 Month Questionnaire

19 months 0 days through 20 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. 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? *(Mark "yes" even if her words are difficult to understand.)*	◯	◯	◯	___
2. Does your child say eight or more words in addition to "Mama" and "Dada"?	◯	◯	◯	___
3. Without your showing him, does your child ***point*** to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(He needs to identify only one picture correctly.)*	◯	◯	◯	___
4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly ***name*** at least one picture?	◯	◯	◯	___
5. Without your giving him clues by pointing or using gestures, can your child carry out at least ***three*** of these kinds of directions?	◯	◯	◯	___

◯ a. "Put the toy on the table." ◯ d. "Find your coat."

◯ b. "Close the door." ◯ e. "Take my hand."

◯ c. "Bring me a towel." ◯ f. "Get your book."

6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? *(Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")* Please give an example of your child's word combinations:	◯	◯	◯	___

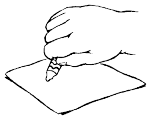
COMMUNICATION TOTAL ___

E101200200

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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)?	◯	◯	◯	___
2. Does your child walk well and seldom fall?	◯	◯	◯	___
3. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	◯	◯	◯	___
4. 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? *(If your child already kicks a ball, mark "yes" for this item.)* 	◯	◯	◯	___
5. Does your child run fairly well, stopping herself without bumping into things or falling? 	◯	◯	◯	___
6. Does your child walk either up or down at least two steps by himself? He may also hold onto the railing or wall. 	◯	◯	◯	___
		GROSS MOTOR TOTAL		___

FINE MOTOR

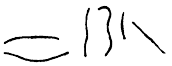
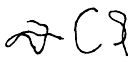
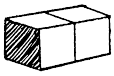
	YES	SOMETIMES	NOT YET	
1. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	◯	◯	◯	___
2. Does your child stack three small blocks or toys on top of each other by herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	◯	◯	◯	___
3. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	◯	◯	◯	___
4. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	◯	◯	◯	___
5. Does your child stack six small blocks or toys on top of each other by himself?	◯	◯	◯	___

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
6. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	◯	◯	◯	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?	◯	◯	◯	___
2. 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 *any direction*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	◯	◯	◯	___
3. If you do any of the following gestures, does your child copy at least one of them?	◯	◯	◯	___
◯ a. Open and close your mouth. ◯ c. Pull on your earlobe. ◯ b. Blink your eyes. ◯ d. Pat your cheek.				
4. If you give your child a bottle, spoon, or pencil upside down, does he turn it right side up so that she can use it properly?	◯	◯	◯	___
5. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up at least *two* blocks side by side? *(You can also use spools of thread, small boxes, or other toys.)* 	◯	◯	◯	___
6. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	◯	◯	◯	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child feed herself with a spoon, even though she may spill some food?	◯	◯	◯	___
2. Does your child get your attention or try to show you something by pulling on your hand or clothes?	◯	◯	◯	___
3. Does your child drink from a cup or glass, putting it down again with little spilling?	◯	◯	◯	___
4. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	◯	◯	◯	___

PERSONAL-SOCIAL *(continued)*

	YES	SOMETIMES	NOT YET	
5. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?	◯	◯	◯	___
6. Does your child eat with a fork?	◯	◯	◯	___

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 her 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 his age? If no, explain: ◯ YES ◯ NO

OVERALL *(continued)*

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

6. Do you have any concerns about your child's vision? If yes, explain: ◯ YES ◯ NO

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

20 Month ASQ-3 Information Summary

19 months 0 days through 20 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	20.50		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	39.89		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	36.05		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	28.84		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	33.36		●	●	●	●	●	●	●	○	○	○	○	○	○

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

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? 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 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						

P101200700

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:** _____

Revised 06.2016