

22 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:



Ages & Stages Questionnaires®

22 Month Questionnaire

21 months 0 days through 22 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:	



22 Month Questionnaire

21 months 0 days through 22 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:

Notes:

- 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 _____.







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. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly <i>name</i> at least one picture?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. Without your giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/> a. "Put the toy on the table." <input type="radio"/> d. "Find your coat."				
<input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand."				
<input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."				
3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least <i>seven</i> body parts? (<i>She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Does your child say 15 or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	<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. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your child walk down stairs if you hold onto one of his hands? He may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	— *
				
	GROSS MOTOR TOTAL			—

*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. 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"/>	—
2. Does your child stack six small blocks or toys on top of each other by himself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PERSONAL-SOCIAL (continued)

	YES	SOMETIMES	NOT YET	_____
2. If you do any of the following gestures, does your child copy at least one of them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/> a. Open and close your mouth.				
<input type="radio"/> b. Blink your eyes.				
<input type="radio"/> c. Pull on your earlobe.				
<input type="radio"/> d. Pat your cheek.				
3. Does your child eat with a fork?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. 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"/>	_____
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?	<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 her age? If no, explain: YES NO

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

OVERALL *(continued)*

4. Do you think your child walks, runs, and climbs like other toddlers his 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

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



22 Month ASQ-3 Information Summary

21 months 0 days through
22 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	13.04		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	27.75		●	●	●	●	●	●	○	○	○	○	○	○	○
Fine Motor	29.61		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.30		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	30.07		●	●	●	●	●	●	○	○	○	○	○	○	○

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: _____