2 Year Well Child Check

Name: _____ **Date: _____**

Diet:

Does child get Calcium 700mg/day and Vitamin D (600 IU/day)? _____

Does child get a variety of solids? _____

Does the family eat meals together at the table? _____

Does child drink milk and water to drink? _____

How much juice and sweet drinks is your child drinking? _____

Dental:

Does child brush his/her teeth? _____

Have you had fluoride treatments done? _____

Has the child been to the dentist? _____

Does child use fluoride toothpaste twice daily? _____

Does child sleep with a bottle or breastfeed during the night? _____

Does child use a pacifier? _____

Elimination:

Has the child started toilet training? _____

How many voids a day? _____

How many stools a day? _____

Sleep:

Is your child getting 11-13 hours of sleep? _____

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 2 years almost all will (please circle yes or no)

- Feed doll yes no
- Remove garments yes no
- Tower of 4 cubes yes no
- Knows 6 body parts yes no
- Uses 2 words together yes no
- Can point out 2 words together yes no
- Can say at least 50 words yes no
- Is understandable by strangers 50% of time yes no
- Runs well and walks up steps yes no
- Can throw a ball overhead yes no

Some children can

- Brush teeth with help yes no
- Wash and dry hands yes no
- Make a tower of 6 cubes yes no
- Can name 4 objects yes no
- Jump up yes no
- Get dressed with help yes no

Social:

Any changes at home or new stressors? _____

ASQ-3™ Ages & Stages Questionnaires®

28 months 16 days through 31 months 15 days

30 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 gender:
◯ Male ◯ Female

Child's date of birth: _____

Person filling out questionnaire

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

Relationship to child:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

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 #: _____

Program ID #: _____

Program name: _____

P101300100

30 Month Questionnaire

28 months 16 days through 31 months 15 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:

_____

_____

_____

_____

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 *name* at least one picture?	◯	◯	◯	___
2. 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."				
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 *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	◯	◯	◯	___
4. Does your child make sentences that are three or four words long? Please give an example:	◯	◯	◯	___
5. Without giving your child help by pointing or using gestures, ask him to "put the book *on* the table" and "put the shoe *under* the chair." Does your child carry out both of these directions correctly?	◯	◯	◯	___
6. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"	◯	◯	◯	___

COMMUNICATION TOTAL ___

E101300200

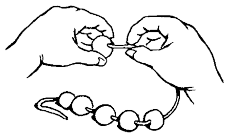
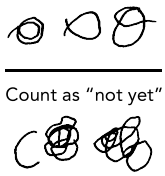
GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling?		○	○	○	___
2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*		○	○	○	___
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		○	○	○	___
4. Does your child jump with both feet leaving the floor at the same time?		○	○	○	___
5. Does your child walk up stairs, using only one foot on each stair? *(The left foot is on one step, and the right foot is on the next.)* She may hold onto the railing or wall.		○	○	○	___ *
6. Does your child stand on one foot for about 1 second without holding onto anything?		○	○	○	___

GROSS MOTOR TOTAL ___

**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

FINE MOTOR

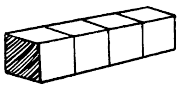
	YES	SOMETIMES	NOT YET	
1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	___
2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction? 	○	○	○	___
3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	___
4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction? 	○	○	○	___
5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle? 	○	○	○	___
6. Does your child turn pages in a book, one page at a time?	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When looking in the mirror, ask, "Where is _____?" *(Use your child's name.)* Does your child point to her image in the mirror? 	○	○	○	___
2. 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 *(continued)*

	YES	SOMETIMES	NOT YET	
3. 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 *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	◯	◯	◯	___
4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? *(Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")* Please write your child's response here: 	◯	◯	◯	___
5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say 'eight two.'" Your child must repeat just one series of two numbers for you to answer "yes" to this question.	◯	◯	◯	___
6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? *(You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)*	◯	◯	◯	___
		PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. 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.				
2. Does your child use a spoon to feed himself with little spilling?	◯	◯	◯	___
3. 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?	◯	◯	◯	___
4. Does your child put on a coat, jacket, or shirt by himself?	◯	◯	◯	___
5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?	◯	◯	◯	___
6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?	◯	◯	◯	___
		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. Can other people understand most of what your child says? If no, explain: ◯ YES ◯ NO

5. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ◯ YES ◯ NO

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

OVERALL *(continued)*

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

8. Has your child had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

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

10. Does anything about your child worry you? If yes, explain: ◯ YES ◯ NO

30 Month ASQ-3 Information Summary

28 months 16 days through 31 months 15 days

Child's name: _____ Date ASQ completed: _____

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

Administering program/provider: _____

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	33.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.14		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.25		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.08		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.01		●	●	●	●	●	●	●	○	○	○	○	○	○

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. Others understand most of what your child says? Yes **NO**
   Comments:
5. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
6. Family history of hearing impairment? **YES** No
   Comments:
7. Concerns about vision? **YES** No
   Comments:
8. Any medical problems? **YES** No
   Comments:
9. Concerns about behavior? **YES** No
   Comments:
10. 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						

P101300800

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