OBERLIN ROAD PEDIATRICS

Well Child Check: 18 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? □ No □ Yes:_____

Does your baby have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does your baby see any specialists outside of ORP? □ No □ Yes: _____

Dental Health:

Have you identified a dentist for your child? □ Yes □ No (we have suggestions on our website)

Does your water source contain Fluoride? □ Yes (city water) □ No (well water)

Is your child completely off the bottle? □ Yes □ No

Are you brushing your child's teeth with fluoridated toothpaste 2x a day? □ Yes □ No

Nutrition:

What type(s) of milk is your child drinking? □ Whole milk □ Breast milk □ Other_____

Are they usually getting 2-3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

Are they usually drinking MORE than 24 oz of milk a day? □ No □ Yes

Are they eating iron-rich foods daily (meat, beans, enriched cereals/cheerios)? □ Yes □ No

Developmental Questions: Does your child….

Walk without holding onto anything or anyone?	Yes	No
Scribble?	Yes	No
Drink from a cup without a lid and may spill sometimes?	Yes	No
Feed themselves with their fingers?	Yes	No
Try to use a spoon?	Yes	No
Climb on and off a couch or chair without help?	Yes	No
Try to say 3 or more words besides mama or dada?	Yes	No
Follow a 1 step direction without any gestures, like giving you a toy when you say "Give it to me."?	Yes	No
Copy you doing chores, like sweeping with a broom?	Yes	No
Play with toys in a simple way, like pushing a toy car/caring for a doll?	Yes	No

Who takes care of your child during the day? _____
Are parents: single married divorced separated
Have there been major changes lately in your baby's or family's life? _____
Will your child travel internationally in the next year? If yes, where, and when? _____

Do you praise your child for good behavior?	Yes	No
If your child is upset, do you help distract him with another toy, book, activity?	Yes	No
Do you read/sing/talk with your child about what you are seeing and doing?	Yes	No
Do you use simple words to tell your child what to do?	Yes	No
Does your child watch TV, tablets, smartphones?	Yes	No
If yes, how many hours a day? (AAP recommends NONE)	_____	
Is your child in a rear-facing carseat every time they ride in a car?	Yes	No
Do you keep your child away from the stove/fireplace/space heaters?	Yes	No
Do you have a gate at the top and bottom of all stairs in your home?	Yes	No
If you have a pool, does it have a locked gate?	Yes	No
Do you keep furniture away from windows on the 2nd floor or higher?	Yes	No
Are your bookcases etc. secured to the wall, not to fall on your child?	Yes	No
Does your child spend time in a place with an unlocked gun?	No	Yes
Do you offer your child a variety of foods? Including vegatables, fruits and proteins?	Yes	No
Is your child willing to try new flavors or textures?	Yes	No
Do you let your child decide whether to eat and how much?	Yes	No

Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes

Name _____ DOB _____

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 *pointing* to it?	○	○	○	___
2. When you ask your child to, does he 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.")*	○	○	○	___
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	○	○	○	___
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? *(Mark "yes" even if her words are difficult to understand.)*	○	○	○	___
5. 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.)*	○	○	○	___
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 ___

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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?	○	○	○	____
2. Does your child move around by walking, rather than by crawling on her hands and knees?	○	○	○	____
3. Does your child walk well and seldom fall?	○	○	○	____
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)?	○	○	○	____
5. 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.)*	○	○	○	____
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? *(If your child already kicks a ball, mark "yes" for this item.)* 	○	○	○	____

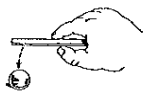
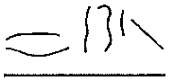
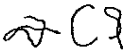
GROSS MOTOR TOTAL ____

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	____
2. Does your child 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.)*	○	○	○	____
3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	○	○	○	____
4. Does your child stack three small blocks or toys on top of each other by himself?	○	○	○	____
5. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	○	○	○	____
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	○	○	○	____

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? *(You may show him how to do it.)*	○	○	○	____
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? 	○	○	○	____
3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? *(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)*	○	○	○	____
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	○	○	○	____
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 *any direction*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	○	○	○	____
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? *(Do not show him how.)*	○	○	○	____

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?	○	○	○	____
2. Does your child play with a doll or stuffed animal by hugging it?	○	○	○	____
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	○	○	○	____
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?	○	○	○	____
5. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	____
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	____

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

E101180600

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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? 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						

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