Sutter Health

Well Child Check: 18 Month Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT ALL PAGES.

Does your child run?	Yes	No	Unsure
Does your child walk up stairs?	Yes	No	Unsure
Can your child kick a ball?	Yes	No	Unsure
Can your child feed self with a spoon?	Yes	No	Unsure
Can your child take some of their clothes off?	Yes	No	Unsure
Can your child scribble?	Yes	No	Unsure
Can your child point to at least one body part when asked?	Yes	No	Unsure
Can your child use at least 4 to 10 words?	Yes	No	Unsure
Does your child follow simple commands? ("get the ball")	Yes	No	Unsure
Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	Unsure
How many ounces of milk does your child drink in 24 hours? _____ oz.	Whole	Low-fat	Nonfat
Is your child completely weaned from the bottle?	Yes	No	Unsure
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	Unsure
Does your child sleep through the night, without feeding?	Yes	No	Unsure
Do you read to your child daily?	Yes	No	Unsure
Does your child show interest in the potty?	Yes	No	Unsure
Is your home child-proofed?	Yes	No	Unsure
Do you usually protect your child with sunscreen / hats / other measures when outdoors?	Yes	No	Unsure
Do you have any other safety concerns at your home? If so, please describe: _____	No	Yes	Unsure
Who provides daytime care for your child? _____			
Does your water contain fluoride?	Yes	No	Unsure
Is your child on any medications or supplements, including fluoride or vitamins? If so, please list them: _____	No	Yes	Unsure
Do you have any international travel plans prior to your child's second birthday? If so, when and where? _____	No	Yes	Unsure

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RISK ASSESSMENT FOR LEAD EXPOSURE:

Does your child live in or regularly visit a house or childcare facility built before 1950?	No	Yes	Unsure
Does your child live in or regularly visit a house or childcare facility built before 1978 that is being or has recently been remodeled (within the last 6 months)?	No	Yes	Unsure
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes	Unsure
Does your child use any imported medicines or supplements?	No	Yes	Unsure

RISK ASSESSMENT FOR TUBERCULOSIS EXPOSURE / INFECTION:

Was your child born outside of the United States? If so, where? _____	No	Yes	Unsure
Has your child ever spent more than a month in any country outside of the United States? If so, where? _____	No	Yes	Unsure
Is your child immunosuppressed – currently or planned?	No	Yes	Unsure
Has your child been in close contact with someone while they had active tuberculosis (TB)?	No	Yes	Unsure

Do you have any concerns about your child's development, or any other concerns you would like to discuss?

If so, please describe:

_____

_____

****CONTINUE TO NEXT PAGE****

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M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1.	If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2.	Have you ever wondered if your child might be deaf?	Yes	No
3.	Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4.	Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5.	Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6.	Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7.	Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8.	Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9.	Does your child show you things by bringing them to you or holding them up for you to see -- not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10.	Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11.	When you smile at your child, does he or she smile back at you?	Yes	No
12.	Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13.	Does your child walk?	Yes	No
14.	Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15.	Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16.	If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17.	Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18.	Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19.	If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20.	Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No