SWYC:™ 15 months

15 months, 0 days to 17 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	0	1	2
Copies sounds that you make	0	1	2
Walks across a room without help	0	1	2
Follows directions - like "Come here" or "Give me the ball"	0	1	2
Runs	0	1	2
Walks up stairs with help	0	1	2
Kicks a ball	0	1	2
Names at least 5 familiar objects - like ball or milk	0	1	2
Names at least 5 body parts - like nose, hand, or tummy	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	(Y)	(N)
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	(Y)	(N)
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	(Y)	(N)
4 Has a family member's drinking or drug use ever had a bad effect on your child?	(Y)	(N)

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	(0)	(1)	(2)	(3)
7 Feeling down, depressed, or hopeless?	(0)	(1)	(2)	(3)

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)

blackmon pediatrics

Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? _____

Can you describe your child's nutritional habits?

1.	Feeding:	Breast	Formula	Milk	Specify Brand: _____	
2.	Feeding Problems:		Yes	No	Specify: _____	
3.	Taking multivitamin with iron		Yes	No		
4.	Number of diapers per day:		Wet _____	Strong urine stream (males): Yes	No	Stool _____
5.	Water Source:		City	Well	Spring	Bottle
6.	Taking solids:		Cereal	Fruits	Veggies	Meats
7.	Appetite:		Good	Variable	Picky	
8.	Weaned from bottle/breast		Yes	No		

Does your child have any problems with the following?

1.	Spitting Up	Yes	No	4.	Sleep	Yes	No
2.	Excessive Crying	Yes	No	5.	Stuffy Nose	Yes	No
3.	Constipation	Yes	No	6.	Diaper Rash	Yes	No

Do you have any concerns about your child's hearing or vision?

Yes No Specify: _____

Lead Screening (please answer for ages 6 months, 9 months, 12 months, and 18 months)

1.	Does your child live in or regularly visit a house built before 1950?	Yes	No
2.	Does your child live in or regularly visit a house built before 1978 with recent renovations?	Yes	No
3.	Does your child have a sibling or playmates that have or have had lead poisoning?	Yes	No
4.	Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking?	Yes	No

Has there been any foreign travel in the last 60 days or international adoption? Yes No

Has there been any exposure to smoking? Yes No Who: _____

Immunizations

1.	Previous reaction to immunizations	Yes	No
2.	Have family members been immunized (mom, dad, sibling)	Yes	No
3.	History of chickenpox in child being seen	Yes	No
4.	Serious illness at home or relatives (cancer)	Yes	No
5.	Allergic to eggs, gelatin, Neomycin, yeast	Yes	No

Please describe your social history.

1.	Race: _____	4.	Ethnicity: _____
2.	Language: _____	5.	# Siblings: _____
3.	Lives With: _____		

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes No Specify: _____

Have there been any changes in your child's medical needs?

1. New problems or illness Yes No Specify: _____
2. Please list current medications (prescription and over-the-counter) _____