



SWYC:TM 18 months

18 months, 0 days to 22 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
Runs	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Walks up stairs with help	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Kicks a ball	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Names at least 5 familiar objects - like ball or milk	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Names at least 5 body parts - like nose, hand, or tummy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Climbs up a ladder at a playground	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Uses words like "me" or "mine"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Jumps off the ground with two feet	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Puts 2 or more words together - like "more water" or "go outside"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Uses words to ask for help	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

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... Seem nervous or afraid?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Seem sad or unhappy?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Get upset if things are not done in a certain way?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Have a hard time with change?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Have trouble playing with other children?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Break things on purpose?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Fight with other children?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Have trouble paying attention?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Have a hard time calming down?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Have trouble staying with one activity?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is your child... Aggressive?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Fidgety or unable to sit still?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Angry?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is it hard to... Take your child out in public?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Comfort your child?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Know what your child needs?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Keep your child on a schedule or routine?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Get your child to obey you?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2

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

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

Does your child bring things to you to show them to you?	Many times a day <input type="radio"/>	A few times a day <input type="radio"/>	A few times a week <input type="radio"/>	Less than once a week <input type="radio"/>	Never <input type="radio"/>
Is your child interested in playing with other children?	Always <input type="radio"/>	Usually <input type="radio"/>	Sometimes <input type="radio"/>	Rarely <input type="radio"/>	Never <input type="radio"/>
When you say a word or wave your hand, will your child try to copy you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look at you when you call his or her name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look if you point to something across the room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants <input type="checkbox"/>	Points to it with one finger <input type="checkbox"/>	Reaches for it <input type="checkbox"/>	Pulls me over or puts my hand on it <input type="checkbox"/>	Grunts, cries or screams <input type="checkbox"/>
<i>(please check all that apply)</i>					
What are your child's favorite play activities?	Playing with dolls or stuffed animals <input type="checkbox"/>	Reading books with you <input type="checkbox"/>	Climbing, running and being active <input type="checkbox"/>	Lining up toys or other things <input type="checkbox"/>	Watching things go round and round like fans or wheels <input type="checkbox"/>
<i>(please check all that apply)</i>					

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi.

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have any concerns about your child's behavior?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?		<input type="radio"/> Y	<input type="radio"/> N					
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?		<input type="radio"/> Y	<input type="radio"/> N					
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?		<input type="radio"/> Y	<input type="radio"/> N					
4 Has a family member's drinking or drug use ever had a bad effect on your child?		<input type="radio"/> Y	<input type="radio"/> 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
<i>Over the past two weeks, how often have you been bothered by any of the following problems?</i>	Not at all	Several days	More than half the days	Nearly every day				
6 Having little interest or pleasure in doing things?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3				
7 Feeling down, depressed, or hopeless?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3				
8 In general, how would you describe your relationship with your spouse/partner?	No tension <input type="radio"/>	Some tension <input type="radio"/>	A lot of tension <input type="radio"/>	Not applicable <input type="radio"/>				
9 Do you and your partner work out arguments with:	No difficulty <input type="radio"/>	Some difficulty <input type="radio"/>	Great difficulty <input type="radio"/>	Not applicable <input type="radio"/>				
10 During the past week, how many days did you or other family members read to your child?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 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 | Yes | No | Specify: _____ | |
| 3. Taking multivitamin with iron | Yes | 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) | _____ | | |

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 <u>unusual</u> 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

