



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 | N/A |
| 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 vegetables, 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 | |



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 <i>pointing</i> to it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 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.") | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Does your child say eight or more words in addition to "Mama" and "Dada"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Without your showing him, does your child <i>point</i> 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 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: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

COMMUNICATION TOTAL _____

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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child move around by walking, rather than by crawling on her hands and knees? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child walk well and seldom fall? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

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 ___

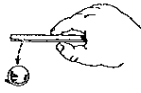
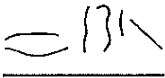
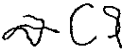
FINE MOTOR

- | | 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child stack three small blocks or toys on top of each other by himself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



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? <i>(You may show him how to do it.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| | | | |  |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? <i>(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? <i>(Mark "not yet" if your child scribbles back and forth.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| | | | | <p>Count as "yes" </p> <p>Count as "not yet" </p> |
| 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? <i>(Do not show him how.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

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

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



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 | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gross Motor | 37.38 | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Fine Motor | 34.32 | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Problem Solving | 25.74 | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Personal-Social | 27.19 | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

- | | | | |
|--|---------------|--|---------------|
| 1. Hears well? Comments: | Yes NO | 6. Concerns about vision? Comments: | YES No |
| 2. Talks like other toddlers his age? Comments: | Yes NO | 7. Any medical problems? Comments: | YES No |
| 3. Understand most of what your child says? Comments: | Yes NO | 8. Concerns about behavior? Comments: | YES No |
| 4. Walks, runs, and climbs like other toddlers? Comments: | Yes NO | 9. Other concerns? Comments: | YES No |
| 5. Family history of hearing impairment? Comments: | Yes NO | | |

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 | | | | | | |