18 Month Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child’s health that you would like to discuss today?
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

What is your child’s health Status?  **Good**  **Fair**  **Poor**

Has your child been to the emergency room in the past 12 months:  **Yes**  **No**
    If yes, list why: ________________________________________________________________

Has your child been treated in the hospital in the past 12 months?  **Yes**  **No**
    If yes, list why: ________________________________________________________________

Has your child ever had any reactions to vaccines / immunizations:  **Yes**  **No**

Has your child seen a dentist in the last 6 months:  **Yes**  **No**

How many times a day does your child brush their teeth?  ___  How many times a day do they floss?  ___

HOME and FAMILY

Who does the child live with:  ___________  How many brothers and sisters does he/she have?  ______

What do you live in?  ___________  How many bedrooms are in your home?  _____

Does your child share a bedroom:  **Yes**  **No**

Does anyone in the home smoke?  **Yes**  **No**

Is your child’s Father Involved in his/her care?  **Yes**  **No**

How is your child’s relationship with his brothers and/or sisters?  **Good**  **Fair**  **Poor**  **N/A, only child**

What type of discipline is used in the home:  **Verbal**  **Time-out**  **Spanking**  **Other:  ___________**

Is there any history of abuse:  **Yes**  **No**  Is there any history of neglect?  **Yes**  **No**

Does anyone in home use drugs:  **Yes**  **No**  Is there a history of domestic violence?  **Yes**  **No**

Has CPS ever been to your home?  **Yes**  **No**  If yes, is your CPS case still open?  **Yes**  **No**

Has your child ever been in foster care?  **Yes**  **No**  If yes, how many times?  _____

Are you feeling stressed?  **Yes**  **No**

Do you have pets in the home?  **Yes**  **No**  If yes, what type?  ___________
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GENERAL HEALTH

What type of milk does he/she drink? Breast milk  Whole  2%  1%  Fat free  Lactose free  Soy
How much milk/formula does he/she drink in a day?  < 8oz  8-16 oz  16-24 oz  24-32oz  > 32oz
What else does he/she drink and how many glasses a day does he/she drink?  ___ Glasses of juice
___ Glasses of water  ___ glasses of caffeinated soda or tea  ___ glasses of decaffeinated soda or tea

Does your child drink from:  cup  bottle only  cup and bottle  phasing out bottle

Does your child eat:  table foods  adequate fruits/vegetables  meat  whole grains

Does your child have any problems with bowel movements, including constipation or diarrhea?  Yes  No
Is he/she toilet trained?  Yes  Daytime only  In process  No
Does he/she have any problems sleeping?  Yes  No  If yes, what kind of problems?  ______________
How would you describe your child’s temperament?  Happy  Fussy  Easy  Demanding
Cries when hungry or with needs  Fussy all the time  Fussy at night  Fussy but consolable

Do you have any concerns about:

Your child’s development?  Yes  No
Your child’s behavior?  Yes  No

HEARING

Does your child:

Understand simple “yes/no” questions  Yes  No
Understand simple phrases (“in the cup”)  Yes  No
Enjoy being read to and points to pictures when asked  Yes  No
Uses his/her own first name  Yes  No
Uses “my” to get toys and other objects  Yes  No
Tells experiences using jargon and words  Yes  No
Uses 2-word sentences like “my shoes”, “go bye-bye”, “more juice”  Yes  No
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VISION
Do you have any concerns about how your child sees Yes No
Does your child hold objects close when trying to focus? Yes No
Do your child’s eyes appear unusual or seem to cross, drift, or be lazy? Yes No
Do your child’s eyelids droop or does one eyelid tend to close? Yes No
Have your child’s eyes ever been injured? Yes No

Check off each task that your child is able to do:

- Runs
- Walks backwards
- Kicks ball
- Throws ball
- Sacks 2 items
- Scribbles
- Turns pages
- Uses 3-6 words
- Combines two words
- Points to 2-4 body parts
- Follows directions
- Names picture (Dog, cat, person)
- Uses spoon/fork

GENERAL SAFETY
Does your child always use a car seat? Yes No
Is your home childproofed? Yes No
Do you have these things in your home:

- Smoke detector Yes No
- Carbon monoxide detector Yes No
- Fire extinguisher Yes No

Revision Date: 5/17/2016
Next Review Date: 5/17/2019
18 Month Well Child Exam Form

18 Month Questionnaire

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

☐ Try each activity with your child 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 ____________.

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

1. When your child wants something, does she tell you by pointing to it?
   ☐ YES ☐ SOMETIMES ☐ NOT YET  

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.")
   ☐ YES ☐ SOMETIMES ☐ NOT YET  

3. Does your child say eight or more words in addition to "Mama" and "Dada"?
   ☐ YES ☐ SOMETIMES ☐ NOT YET  

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.)
   ☐ YES ☐ SOMETIMES ☐ NOT YET  

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)
   ☐ YES ☐ SOMETIMES ☐ NOT YET  

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

1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

2. Does your child move around by walking, rather than by crawling on her hands and knees?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

3. Does your child walk well and seldom fall?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

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)?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

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.)  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

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.)  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

**GROSS MOTOR TOTAL:**

### FINE MOTOR

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.)  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

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.)  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

4. Does your child stack three small blocks or toys on top of each other by himself?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

6. Does your child get a spoon into her mouth right side up so that the food usually doesn’t spill?  
   - [ ] Yes  
   - [ ] Sometimes  
   - [ ] Not Yet

**FINE MOTOR TOTAL:**
## PROBLEM SOLVING

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.)
   - Yes
   - Sometimes
   - Not Yet

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?
   - Yes
   - Sometimes
   - Not Yet

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.)
   - Yes
   - Sometimes
   - Not Yet

4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?
   - Yes
   - Sometimes
   - Not Yet

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.)
   - Yes
   - Sometimes
   - 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.)
   - Yes
   - Sometimes
   - Not Yet

**PROBLEM SOLVING TOTAL**

---

## PERSONAL-SOCIAL

1. While looking at herself in the mirror, does your child offer a toy to her own image?
   - Yes
   - Sometimes
   - Not Yet

2. Does your child play with a doll or stuffed animal by hugging it?
   - Yes
   - Sometimes
   - Not Yet

3. Does your child get your attention or try to show you something by pulling on your hand or clothes?
   - Yes
   - Sometimes
   - Not Yet

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?
   - Yes
   - Sometimes
   - Not Yet

5. Does your child drink from a cup or glass, putting it down again with little spilling?
   - Yes
   - Sometimes
   - Not Yet

6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?
   - Yes
   - Sometimes
   - Not Yet

**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

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18 Month Questionnaire  page 8 of 6

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 Well Child Exam Form

**M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)**

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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you point at something across the room, does your child look at it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Have you ever wondered if your child might be deaf?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Does your child make unusual finger movements near his or her eyes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(FOR EXAMPLE, pointing to a snack or toy that is out of reach)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Does your child point with one finger to ask for something or to get help?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Does your child point with one finger to show something interesting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. When you smile at your child, does he or she smile back at you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Does your child walk?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16. If you turn your head to look at something, does your child look around to see what you are looking at?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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”?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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”?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>