

CASTLE VALLEY CHILDRENS' CLINIC

Health Maintenance Visit

9 MO - 12 MO

Patient Name _____

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO THE DOUBLE LINE (please circle and check appropriate answers)

NUTRITION

- | | | | |
|---|--------------------------|-----------------------|------------------|
| 1. Are you breastfeeding or bottlefeeding your baby now? | | Breast | Bottle |
| 2. Has your baby started to use a cup yet? | | yes | no |
| 3. Are you giving your baby vitamins, iron or fluoride? | | yes | no |
| 4. Please check kind of food and approximately how much your baby eats: | | | |
| Milk _____ | Amount in a bottle _____ | Amount in a cup _____ | |
| Juice _____ | Amount _____ | Vegetables _____ | Amount _____ |
| Cereal _____ | Amount _____ | Meats _____ | Amount _____ |
| Fruits _____ | Amount _____ | Snacks _____ | What kind? _____ |
| 5. Does your child feed himself/herself finger foods? | | yes | no |
| 6. Is your baby having any problems with eating? | | yes | no |
| 7. Is your child on WIC or Denver Food Supplemental Program? | | yes | no |

ELIMINATION

- | | | |
|---|-----|----|
| 8. Have you notice a strong or unusual smell of your child's urine? | yes | no |
| 9. Has your child had any problems with constipation or diarrhea? | yes | r |

BEHAVIOR

- | | | |
|---|-----|----|
| 10. Is your child having any problems with sleeping? | yes | no |
| 11. How many hours does your baby sleep at night? _____ hours | | |
| 12. How many naps does he/she take? _____ naps | | |
| 13. Does your child have any behaviors you would like to change?
List Behavior _____ | yes | no |
| 14. Is there anything which upsets you or concerns you about your child? | yes | no |
| 15. Does you feel you have a difficult child? | yes | no |

DEVELOPMENT

16. All children learn things at different times. At this point in your child's development, check which of the following he/she can do.
- | | | |
|---------------------------------------|--|----------------------|
| ____ Sit without support for a minute | ____ Pull himself to standing position | ____ Play peek-a-boo |
| ____ Bang two cubes together | ____ Stand alone | ____ Say mama, dada |
| ____ Creep or crawl | ____ Walk, holding onto furniture | ____ Play pat-a-cake |

ILLNESS

- | | | |
|--|-----|----|
| 17. Has your baby had any illnesses or needed to see a doctor since your last visit? | yes | no |
| 18. If your child is on any medications, please name them: _____ | | |

REVIEW OF SYSTEMS (Check if your child has any of the following since the last visit.)

- | | | |
|---------------------------------------|---------------------------------|---------------------------------|
| ____ Accidents/injury/unconsciousness | ____ Nasal congestion | ____ Allergies |
| ____ Ear infection | ____ Trouble breathing | ____ Skin rashes |
| ____ Hearing problems | ____ Frequent colds or coughing | ____ Big weight gain or loss |
| ____ Eye infections or drainage | ____ High fever | ____ Recent weight gain or loss |

OBJECTIVE: _____

NURSING DIAGNOSIS: _____

PLAN: (Anticipatory guidance checklist on page 1)

PROVIDER SIGNATURE _____



Ages & Stages Questionnaires®



12 Month Questionnaire

11 months 0 days through 12 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Baby's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to baby:
 Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



12 Month Questionnaire

11 months 0 days
through 12 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:

Notes:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When your baby wants something, does he tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—



COMMUNICATION TOTAL —

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—







GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|--|---|-----------------------|-----------------------|---|
| 4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 6. Does your baby stand up in the middle of the floor by himself and take several steps forward? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

GROSS MOTOR TOTAL —

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|---|-----------------------|-----------------------|----|
| 1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be attached to a toy.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —* |
| |  | | | |
| 5. Does your baby 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"/> | — |
| |  | | | |
| 6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

FINE MOTOR TOTAL —

*If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? <i>(Be sure the toy is completely hidden.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? <i>(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby drop two small toys, one after the other, 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"/> | — * |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? <i>(If she already scribbles on her own, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



PROBLEM SOLVING TOTAL

**If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."*

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? <i>(If he already lets go of the toy into your hand, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | <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. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. Does your baby play with sounds or seem to make words? If no, explain:

YES

NO

3. When your baby is standing, are her feet flat on the surface most of the time?
If no, explain:

YES

NO

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain:

YES

NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

OVERALL (continued)

6. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

7. Has your baby had any medical problems in the last several months? If yes, explain:

 YES NO

8. Do you have any concerns about your baby's behavior? If yes, explain:

 YES NO

9. Does anything about your baby worry you? If yes, explain:

 YES NO



12 Month ASQ-3 Information Summary

11 months 0 days through
12 months 30 days

Baby's name: _____ Date ASQ completed: _____
 Baby'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	15.64		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	21.49		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	34.50		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	27.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	21.73		●	●	●	●	●	○	○	○	○	○	○	○	○

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

- | | | | |
|--|---------------|--|---------------|
| 1. Uses both hands and both legs equally well?
Comments: | Yes NO | 6. Concerns about vision?
Comments: | YES No |
| 2. Plays with sounds or seems to make words?
Comments: | Yes NO | 7. Any medical problems?
Comments: | YES No |
| 3. Feet are flat on the surface most of the time?
Comments: | Yes NO | 8. Concerns about behavior?
Comments: | YES No |
| 4. Concerns about not making sounds?
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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
 If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the baby'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						