CASTLE VALLEY CHILDRENS CLINIC

Health Maintenance Visit

15 MO - 18 MO

Patient Name _____ _____ **MR#** _____

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO DOUBLE LINE (please circle)

NUTRITION (Subjective)

PARENT: HOW MANY SERVINGS OF EACH OF THE 4 FOOD GROUPS DOES YOUR CHILD EAT EACH DAY?
(Please write number of servings in space provided after reviewing **examples** of serving size for this age group.)

MILK	MEAT	FRUITS & VEGETABLES	GRAINS
1/2 cup milk	1/2 sm. hamburger	2-3 Tbsp. cooked fruit or vegetable	1/2 slice bread
1/2 cup yogurt	1/4 cup tuna	1/2 cup raw fruit or vegetable	1/2 cup cold cereal
3/4 cup ice cream	1/2 drumstick	1/2 cup juice	1/4 cup hot cereal
2/3 cup cottage cheese	1 egg		4 graham crackers
1 oz cheese	1 slice meat		1/4 cup rice potatoes or noodles
	2 Tbsp. nuts, sunflower seeds or peanut butter		
_____ # of servings my child eats each day	_____ # of servings my child eats each day	_____ # of servings my child eats each day	_____ # of servings my child eats each day

2. List snack foods _____
3. Does your child use a spoon and cup? ..... YES
4. Is your baby having any problems with eating? ..... NO YES
5. Is your baby on WIC or Denver Food Supplemental Program? ..... YES NO

ELIMINATION

6. Does your child have pain with urination, frequent urination, weak or dribbling stream, strong or funny smell of urine? ..... NO YES
7. Does your child experience constipation or diarrhea? ..... NO YES

BEHAVIOR

8. Is your child having any problems with sleeping? ..... NO YES
9. Sleeps from _____ pm to _____ am Number of naps _____
10. Does your child have any behaviors you would like to change? ..... NO YES
11. What do you do when your child doesn't mind? _____
12. Does your child spend time with other children? ..... YES NO
13. Do you brush your child's teeth every day? ..... YES NO

DEVELOPMENT

14. All children learn things at different times. At this point in your child's development, check which of the following he/she can do.

___ Walk unaided
___ Point to eyes, nose, other body parts when asked
___ Say three words other than mama and dada
___ Walk up and down steps holding on
___ Understand simple instructions
___ Pick up raisin-sized objects
___ Imitate housework

ILLNESSES

15. If your child is on any medicines, name them: _____
16. Has your child had any serious illnesses or needed to see a doctor since the last check-up? ..... NO YES
17. Is there anything about your child that worries or upsets you? ..... NO YES

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

___ Accidents/injury/unconsciousness
___ Ear infections/earaches
___ Vision or hearing problems
___ Eye infections
___ Nasal congestion
___ Trouble breathing
___ Frequent colds or coughing
___ High fever
___ Allergies
___ Skin rashes
___ Big weight gain or loss
___ Recent change in home/family

OBJECTIVE:

NURSING DIAGNOSIS:

PLAN: (Anticipatory guidance checklist on page 1)

SIGNATURE _____

ASQ-3 Ages & Stages Questionnaires®

15 months 0 days through 16 months 30 days

16 Month Questionnaire

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

Date ASQ completed: _____

Child's information

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

Child's date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

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

Relationship to child:
◯ 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

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

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

Program name: _____

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ASQ-3

16 Month Questionnaire

15 months 0 days through 16 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. Does your child point to, pat, or try to pick up pictures in a book?	○	○	○	___
2. Does your child say four or more words in addition to "Mama" and "Dada"?	○	○	○	___
3. When your child wants something, does she tell you by *pointing* to it?	○	○	○	___
4. 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.")*	○	○	○	___
5. 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.)*	○	○	○	___
6. Does your child say eight or more words in addition to "Mama" and "Dada"?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child stand up in the middle of the floor by himself and take several steps forward?	○	○	○	___
2. Does your child climb onto furniture or other large objects, such as large climbing blocks?	○	○	○	___
3. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	○	○	○	___

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GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your child move around by walking, rather than crawling on her hands and knees?	○	○	○	___
5. Does your child walk well and seldom fall?	○	○	○	___
6. 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)?	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

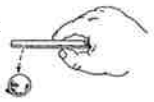
	YES	SOMETIMES	NOT YET	
1. Does your child help turn the pages of a book? *(You may lift a page for her to grasp.)*	○	○	○	___
2. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	___
3. Does your child stack a small block 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.)*	○	○	○	___
4. Does your child stack three small blocks or toys on top of each other by herself?	○	○	○	___
5. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	○	○	○	___
6. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. After you scribble back and forth on paper with a crayon (or pencil or pen), does your child copy you by scribbling? *(If she already scribbles on her own, mark "yes" for this item.)*	○	○	○	___
2. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?	○	○	○	___
3. 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.)*	○	○	○	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
4. 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? 	○	○	○	___
5. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?	○	○	○	___ *
6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump it out? *(You may show her how.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 5 is marked "yes," mark Problem Solving Item 1 as "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child feed himself with a spoon, even though he may spill some food?	○	○	○	___
2. Does your child help undress herself by taking off clothes like socks, hat, shoes, or mittens?	○	○	○	___
3. Does your child play with a doll or stuffed animal by hugging it?	○	○	○	___
4. While looking at himself in the mirror, does your child offer a toy to his own image?	○	○	○	___
5. Does your child get your attention or try to show you something by pulling on your hand or clothes?	○	○	○	___
6. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?	○	○	○	___

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

OVERALL *(continued)*

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

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

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

16 Month ASQ-3 Information Summary

15 months 0 days through 16 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	16.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	37.91		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	31.98		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	30.51		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.43		●	●	●	●	●	●	○	○	○	○	○	○	○

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

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

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						

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