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 cup yogurt 3/4 cup ice cream 2/3 cup cottage cheese 1 oz cheese	1/2 sm. hamburger 1/4 cup tuna 1/2 drumstick 1 egg 1 slice meat 2 Tbsp. nuts, sunflower seeds or peanut butter	2-3 Tbsp. cooked fruit or vegetable 1/2 cup raw fruit or vegetable 1/2 cup juice	1/2 slice bread 1/2 cup cold cereal 1/4 cup hot cereal 4 graham crackers 1/4 cup rice, potatoes or noodles
_____ # 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 _____

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 unusual 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