UW Medicine
PRIMARY CARE

Fifteen-Month-Old Well Child Visit

Child's Name_____ Child's Age_____ Date_____

Person completing the form_____ Relationship to the patient_____

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

Nutrition:	**Yes**	**No**
Is your child drinking whole milk, limited to no more than 20 ounces per day?	( )	( )
Have you weaned your child from the bottle?	( )	( )
Is juice or sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child regularly take a supplement that contains vitamin D?	( )	( )
On average, does your child eat fast food one or more times per week?	( )	( )

Family and Social History:	**Yes**	**No**
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:	**Yes**	**No**
How many hours of TV or videos is your child exposed to per day? _____		
Does your child always ride in a car seat, in the back seat, facing backwards?	( )	( )
Do you, anyone in your home, or anyone who cares for your child smoke?	( )	( )
Does your child have at least one hour of active play per day?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (visited Africa, Asia, Latin America, Caribbean Country, been homeless or jailed, IV user, HIV positive)?	( )	( )

Oral Health:	**Yes**	**No**
Have you found a dentist for your child yet?	( )	( )

Behavioral/Mental Health:	**Yes**	**No**
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well, without snoring?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
• If yes, do you need assistance to find a suitable program?	( )	( )

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

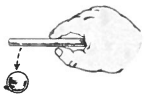
	YES	SOMETIMES	NOT YET	
1. Does your child help turn the pages of a book? *(You may lift a page for her to grasp.)*	○	○	○	___
2. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	___
3. Does your child stack a small block 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