# 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:

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

## Family and Social History:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any major illnesses in the family that we are not already aware of?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Are there any major stressors in the family (illness, moves, death, separation)?</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

## Preventative Health/Risk Factors:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many hours of TV or videos is your child exposed to per day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child always ride in a car seat, in the back seat, facing backwards?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Do you, anyone in your home, or anyone who cares for your child smoke?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Does your child have at least one hour of active play per day?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>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)?</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

## Oral Health:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you found a dentist for your child yet?</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

## Behavioral/Mental Health:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child have a regular sleep routine?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Does your child sleep well, without snoring?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Do you have any concerns about how your child is learning, developing and behaving?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Are you interested in enrolling your child in daycare?</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>• If yes, do you need assistance to find a suitable program?</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
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: ___________________________

If child was born 3 or more weeks prematurely, # of weeks premature: __________

Child's date of birth: _________________________

Child's gender:  
- Male  
- Female

Person filling out questionnaire

First name: ___________________________  Middle initial: __________  Last name: ___________________________

Relationship to child:  
- Parent  
- Guardian  
- Teacher  
- Child care provider  
- 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: ___________________________
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.

<table>
<thead>
<tr>
<th>Important Points to Remember</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Try each activity with your baby before marking a response.</td>
<td></td>
</tr>
<tr>
<td>✓ Make completing this questionnaire a game that is fun for you and your child.</td>
<td></td>
</tr>
<tr>
<td>✓ Make sure your child is rested and fed.</td>
<td></td>
</tr>
<tr>
<td>✓ Please return this questionnaire by ______________.</td>
<td></td>
</tr>
</tbody>
</table>

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. Does your child point to, pet, or try to pick up pictures in a book?
   - [ ] Yes
   - [ ] Sometimes
   - [ ] Not Yet

2. Does your child say four or more words in addition to “Mama” and “Dada”?
   - [ ] Yes
   - [ ] Sometimes
   - [ ] Not Yet

3. When your child wants something, does she tell you by pointing to it?
   - [ ] Yes
   - [ ] Sometimes
   - [ ] Not Yet

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

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

6. Does your child say eight or more words in addition to “Mama” and “Dada”?
   - [ ] Yes
   - [ ] Sometimes
   - [ ] Not Yet

**COMMUNICATION TOTAL**

### GROSS MOTOR

1. Does your child stand up in the middle of the floor by himself and take several steps forward?
   - [ ] Yes
   - [ ] Sometimes
   - [ ] Not Yet

2. Does your child climb onto furniture or other large objects, such as large climbing blocks?
   - [ ] Yes
   - [ ] Sometimes
   - [ ] Not Yet

3. 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
GROSS MOTOR (continued)

4. Does your child move around by walking, rather than crawling on her hands and knees?
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

5. Does your child walk well and seldom fall?
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

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)?
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

GROSS MOTOR TOTAL

FINE MOTOR

1. Does your child help turn the pages of a book? (You may lift a page for her to grasp.)
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

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.)
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

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.)
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

4. Does your child stack three small blocks or toys on top of each other by herself?
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

5. 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
   ○            ○                ○            

6. 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
   ○            ○                ○            

FINE MOTOR TOTAL

PROBLEM SOLVING

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.)
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

2. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

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.)
   YES          SOMETIMES          NOT YET
   ○            ○                ○            

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PROBLEM SOLVING  
(continued)

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

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
2. Do you think your child talks like other toddlers his age? If no, explain:


3. Can you understand most of what your child says? If no, explain:


4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain:


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


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


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


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