Child's Name: _____ Date: _____

Westwood Office
541 High Street
Westwood, MA 02090
(781) 326-7700

Westwood-Mansfield Pediatric Associates

Mansfield Office
454 Chauncy Street
Mansfield, MA 02048
(508) 339-9944

www.wmpeds.com

18 MONTH OLD PARENT SURVEY

DEVELOPMENT

Does your child:

Have a vocabulary of more than 10 words?	N	Y
Point with one finger?	N	Y
Eat with a fork or spoon?	N	Y
Walk?	N	Y
Run?	N	Y
Climb?		
Have a high needs temperament?	Y	N

Do your other children have high needs temperaments?		Y	N
Do you read to your child for 20 minutes a day?		N	Y
Is your child shy?		Y	N
Do you have concerns about your child's relationship with his/her siblings?	N/A	Y	N

DIET

Do you have concerns about your child's diet?			Y	N
Are you worried about your child's growth?	Yes	Somewhat		No
Does your child still drink from a bottle?			Y	N

How many ounces of milk does your child drink each day? _____

How many ounces of juice does your child drink each day?_____

Would you like some literature on diet for children?	Y	N

ELIMINATION

Do you have concerns about your child's toileting habits?	Y	N

How many stools does your child have per day? _____

Does your child routinely have hard stools or diarrhea?	Y	N

SLEEP

Do you have concerns about your child's sleep?			Y	N
With whom does your child sleep?	help me	parent	sibling	self
Does your child sleep through the night?			N	Y
Does your child still nap?	N	sometimes		Y

HEALTH OF FAMILY

Who lives with your child? _____

Are there any significant marital, health, financial or employment stresses at home?	Y	N

If yes, please explain (if you would like) _____

Are you: married partnered separated divorced single widowed

Do you or your partner have depression or anxiety?	Y	N
Has there been any change in employment status (new job or lost job) for you or your partner in the last year?	Y	N
Do you have enough support with childcare?	N	Y
Are you involved with playgroups?	N	Y
Does anyone in your household use tobacco?	Y	N
If yes, would you like information on quitting?	Y	N
Does anyone in your house have issues with alcohol/drugs?	Y	N
Do you feel safe in your own home?	N	Y

DENTAL HEALTH

Has your child seen a dentist?		N	Y
Do you brush your child's teeth at least twice a day?		N	Y
Do you floss your child's teeth at least once a day?		N	Y
Is there fluoride in the water that your child drinks at home?	Don't know	N	Y
Does your child still use a pacifier?		Y	N

SAFETY

How much "screen time" does your child have? _____

Is your child in a rear-facing car seat?	N	Y
Is there a swimming pool at or near your home?	Y	N
Is there a gun in your home?	Y	N

HEALTH CARE MAINTENANCE

Has your child travelled outside the country this year?	Y	N
Has your child been to an ER or specialist this year?	Y	N

Do you have any questions about your child for today's visit?

1. _____
2. _____

PLEASE TURN OVER AND COMPLETE BOTH SIDES!!!!

If you smoke and want to quit 1-800-TRY-TO-STOP
If you feel you have an alcohol problem contact Alcoholics Anonymous.....1-800-443-9484
National Suicide Prevention Hotline number.....1-800-273-8255
Remember to check smoke detector/carbon monoxide detector batteries every 6 months.

Boston Children's Hospital
Community of Care
Preferred Pediatric Practice

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M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

	Yes	No
1. Does your child enjoy being swung, bounced on your knee, etc.?	□	□
2. □ Does your child take an interest in other children?	□	□
3. Does your child like climbing on things, such as up stairs?	□	□
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	□	□
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	□	□
6. Does your child ever use his/her index finger to point, to ask for something?	□	□
7. □ Does your child ever use his/her index finger to point, to indicate interest in something?	□	□
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	□	□
9. □ Does your child ever bring objects over to you (parent) to show you something?	□	□
10. Does your child look you in the eye for more than a second or two?	□	□
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	□	□
12. Does your child smile in response to your face or your smile?	□	□
13. □ Does your child imitate you? (e.g., you make a face-will your child imitate it?)	□	□
14. □ Does your child respond to his/her name when you call?	□	□
15. □ If you point at a toy across the room, does your child look at it?	□	□
16. Does your child walk?	□	□
17. Does your child look at things you are looking at?	□	□
18. Does your child make unusual finger movements near his/her face?	□	□
19. Does your child try to attract your attention to his/her own activity?	□	□
20. Have you ever wondered if your child is deaf?	□	□
21. Does your child understand what people say?	□	□
22. Does your child sometimes stare at nothing or wander with no purpose?	□	□
23. Do Does your child look at your face to check your reaction when faced with something unfamiliar?	□	□