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www.wmpeds.com

## 18 MONTH OLD PARENT SURVEY

Patients Name: \_\_\_\_\_ Date: \_\_\_\_\_

### 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 other

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?

\_\_\_\_\_  
 \_\_\_\_\_

**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.

[6/17]

**PLEASE TURN OVER AND COMPLETE BOTH SIDES!!**



## 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?<br>( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , furniture, playground equipment, or stairs)   | Yes | No |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?<br>( <b>FOR EXAMPLE</b> , 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?<br>( <b>FOR EXAMPLE</b> , 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?<br>( <b>FOR EXAMPLE</b> , pointing to an airplane in the sky or a big truck in the road)   | Yes | No |
| 8. Is your child interested in other children? ( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , 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? ( <b>FOR EXAMPLE</b> , 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?<br>( <b>FOR EXAMPLE</b> , 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?<br>( <b>FOR EXAMPLE</b> , 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?<br>( <b>FOR EXAMPLE</b> , being swung or bounced on your knee)   | Yes | No |