



FAMILY HEALTH

A S S O C I A T E S

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PEDIATRIC HEALTH MAINTENANCE – 12 MONTHS PATIENT QUESTIONNAIRE

General

Do you have any concerns about your baby? Yes ___ No ___

If “yes,” please specify:

Is your child in daycare or in the care of a babysitter? Yes ___ No ___

Do you have any concerns about your child’s vision or hearing? Yes ___ No ___

Do your child’s eyes ever appear to cross or drift apart? Yes ___ No ___

Feeding and Sleeping

How is your child fed? Breast Bottle Cup

Are you giving your baby any vitamins? No Vitamin D Other

Does your child eat a good variety of foods? Yes ___ No ___

Does your baby sleep through the night? Yes ___ No ___

Does your baby sleep with a bottle? Yes ___ No ___

Environment

What type of housing do you have? House Apartment Manufactured Home

What year was your home built? _____

Who lives with you in your home? _____

Do you have pets? Yes ___ No ___

Does anyone smoke in your house? Yes ___ No ___

Safety

Does your home have functioning smoke detectors? Yes ___ No ___

Are your windows locked? Are any guns in your home securely stored? Yes ___ No ___

Do you have a pool? Yes ___ No ___

Are all medicines and household products locked up? Yes ___ No ___

If you have stairs, are they blocked off? Yes ___ No ___

Do you leave your baby alone in the bath? Yes ___ No ___

Are small objects kept out of your baby’s reach at all times? Yes ___ No ___

Does your baby ride in a rear-facing car seat, in the back seat? Yes ___ No ___

Are you afraid of your partner or anyone close to you? Yes ___ No ___

Do you feel overly stressed or unsupported? Yes ___ No ___

Patient Name: _____

Completed by (name and relationship to patient): _____ Date: _____



Ages & Stages Questionnaires®

12 Month Questionnaire

11 months 0 days through 12 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other: _____

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

Baby 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.

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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION



	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," <i>without</i> your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When your baby wants something, does he tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

GROSS MOTOR





	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
<p>4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? <i>(If your baby already walks alone, mark "yes" for this item.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>5. When you hold <i>one hand</i> just to balance your baby, does she take several steps forward? <i>(If your baby already walks alone, mark "yes" for this item.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>6. Does your baby stand up in the middle of the floor by himself and take several steps forward?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
GROSS MOTOR TOTAL				_____

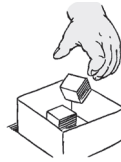
FINE MOTOR

	YES	SOMETIMES	NOT YET	
<p>1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? <i>(The string may be attached to a toy.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>2. Does your baby pick up a crumb or Cheerio with the <i>tips</i> of her thumb and a finger? She may rest her arm or hand on the table while doing it.</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<p>4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the <i>tips</i> of her thumb and a finger?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*
				
<p>5. Does your baby throw a small ball with a forward arm motion? <i>(If he simply drops the ball, mark "not yet" for this item.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>6. Does your baby help turn the pages of a book? <i>(You may lift a page for him to grasp.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
FINE MOTOR TOTAL				_____

**If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? <i>(Be sure the toy is completely hidden.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? <i>(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? <i>(You may show him how to do it.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ * |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? <i>(If she already scribbles on her own, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



PROBLEM SOLVING TOTAL

**If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."*

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? <i>(If he already lets go of the toy into your hand, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PERSONAL-SOCIAL TOTAL

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. Does your baby play with sounds or seem to make words? If no, explain:

YES

NO

3. When your baby is standing, are her feet flat on the surface most of the time?
If no, explain:

YES

NO

4. Do you have concerns that your baby is too quiet or does not make sounds like
other babies do? If yes, explain:

YES

NO

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

YES

NO

OVERALL (continued)

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

 YES NO

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

 YES NO

8. Do you have any concerns about your baby's behavior? If yes, explain:

 YES NO

9. Does anything about your baby worry you? If yes, explain:

 YES NO



12 Month ASQ-3 Information Summary

11 months 0 days through
12 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	15.64		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	21.49		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	34.50		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	27.32		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	21.73		●	●	●	●	●	○	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Plays with sounds or seems to make words?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Concerns about not making sounds?
Comments: | YES | No | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
Comments: | YES | No | | | |

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



Well Child: 12 Months

Name: _____ Date: _____ Length: _____ in. (_____ %)

Weight: _____ lbs. _____ oz. (_____ %) Head Circumference: _____ cm. (_____ %)

IMMUNIZATIONS: Varicella (1st dose), Hep A (1st dose), Hib (3rd dose), Polio (3rd dose), MMR (1st dose), PCV (4th dose)

IBUPROFEN (Advil, Motrin) & ACETAMINOPHEN (Tylenol) DOSAGE

Child's Weight	Ibuprofen Infant Dose (50 mg/1.25mL)	Acetaminophen Infant's Suspension (160mg/5mL)
6-12lbs	X	1.25mL
12-18lbs	1.25mL	2.5mL
18-24lbs	1.875mL	3.75mL (3/4 tsp)
24-28lbs	1.25mL + 1.25mL	5mL (1 tsp)
Over 28lbs	1.875mL + 1.25mL	5mL (1 tsp)

Ibuprofen may be given every 6 hours, but not more than 4 times in 24 hours. CHECK THE CONCENTRATION OF THE IBUPROFEN YOU ARE USING

Acetaminophen may be given every 4 hours, but not more than four times in 24 hours. Please call the office if fever persists for more than 2 days or if you have any questions.

NEXT VISIT: 15 months

<u>Feeding Your Child</u>	<u>Establishing Routines</u>
<p>DO:</p> <ul style="list-style-type: none"> ▪ Be patient as your child learns to eat without help. ▪ Encourage your child to feed themselves. ▪ Emphasize healthy foods. ▪ Give 3 meals and 2-3 snacks a day. ▪ Use a small plate and cup for eating and drinking. ▪ Make sure caregivers follow the same ideas and routines for meals that you do. ▪ Let baby decide what and how much to eat. <p>DON'T:</p> <ul style="list-style-type: none"> ▪ Give foods that are choking hazards (ex. raw apple, nuts, large chunks). 	<ul style="list-style-type: none"> ▪ Praise your child when they do what you ask them to do. ▪ Use short and simple rules for your child. ▪ Try not to hit, spank, or yell at your child. ▪ Use short time-outs when your child isn't following directions. ▪ Distract your child with something they like when they start to get upset. ▪ Play with and read to your child often. ▪ Your child should have at least one nap a day. ▪ Make the hour before bedtime loving and calm, with reading, singing, and a favorite toy.
<p><u>Finding a Dentist</u></p> <ul style="list-style-type: none"> ▪ Take your child for a first dental visit as soon as their first tooth erupts or by 12 months of age. ▪ Brush your child's teeth twice a day with a soft toothbrush. Use a small smear of fluoride toothpaste ▪ If you are still using a bottle, offer only water. 	<ul style="list-style-type: none"> ▪ Avoid letting your child watch TV or play on a tablet or smartphone. ▪ Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.

Safety

- Consistent messages are vital. If an object is a potential danger, say “no,” take object away, and replace with a safe substitute. Show your child what to do, not just what not to do.
- Increased mobility provides a bigger challenge for you to keep your child safe. **THOROUGHLY CHILD-PROOF YOUR HOME.**
- Place gates at the top and bottom of stairs.
- Don’t leave hot or heavy things on tablecloths that your child could pull over.
- Put barriers around space heaters and keep electrical cords out of reach.
- Install operable window guards on windows at the second story or higher.
- Keep furniture away from windows.
- Empty buckets, pools, and tubs when you are done using them.
- Never leave your baby in or near water alone.
- Put your baby in a high chair or playpen when in the kitchen.
- Keep chords, balloons, plastic bags, and small objects away from your child. Cover all electrical outlets.
- Keep your child away when your pet is eating. Be close by when they are playing with your pet.
- If you keep a gun at home, store it unloaded and locked up with the ammunition locked separately.
- Always use a properly fitted rear-facing car seat. The center rear seat is safest. If they outgrow their car seat, get a larger one. They should remain rear-facing until they reach the highest height or weight allowed by the manufacturer. This will normally be past their second birthday.
- Your baby’s safety depends on you. Always wear a seat belt; never drive under the influence; and never use your phone while driving.
- Never leave your baby in the car alone.
- Keep poisonous substances locked up and out of reach.
- **IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222**

How Your Family is Doing:

- If you are worried about your living or food situation, reach out for help. Community agencies and programs provide information and assistance.
- Don’t smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy.
- Don’t use alcohol or drugs.
- Make sure everyone who cares for your child offers healthy foods, avoids sweets, provides time for active play, and uses the same rules for discipline that you do.
- Make sure the places your child stays are safe.
- Think about joining a toddler playgroup or taking a parenting class.
- Take time for yourself and your partner.
- Keep in contact with family and friends

WHAT TO EXPECT AT YOUR CHILD’S 15 MONTH VISIT

We will talk about:

- Supporting your child’s speech and independence and making time for yourself
- Developing good bedtime routines
- Handling tantrums and discipline
- Caring for your child’s teeth
- Keeping your child safe at home and in the car