FAMILY HEALTH
ASSOCIATES

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PEDIATRIC HEALTH MAINTENANCE – 15 MONTHS
PATIENT QUESTIONNAIRE

General

Do you have any concerns about your child? 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

What type of milk does your child drink? ☐ Whole ☐ 2% ☐ Skim ☐ Other: ____

How much milk does your child drink each day? _____

Does your child eat a good variety of foods? Yes___ No___

Do you brush your child's teeth? Yes___ No___

Does your child sleep through the night? Yes___ No___

Does your child sleep with a bottle? Yes___ No___

Environment

Who lives with you in your home? _____

Do you have pets? Yes___ No___

Does anyone smoke in your house? Yes___ No___

Safety

Do you give your child raw vegetables, hard candy, gum, nuts, or popcorn? 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, household products, and sharp objects locked up? Yes___ No___

Do you have safety caps on all medicines, vitamins, etc.? Yes___ No___

Do you know what to do if your child ingests a poisonous substance? Yes___ No___

Do you know what to do if your child is choking? Yes___ No___

Do you leave your child alone in the bath? Yes___ No___

Is your child ever in the yard when a lawnmower is in use? 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: _____

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: _____

Street address: _____

Relationship to child: ◯ 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

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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16 Month Questionnaire

15 months 0 days through 16 months 30 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child 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		___

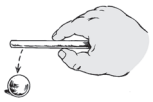
FINE MOTOR

	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

16 Month ASQ-3 Information Summary

15 months 0 days through 16 months 30 days

Child's name: _____ Date ASQ completed: _____

Child'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	16.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	37.91		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	31.98		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	30.51		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.43		●	●	●	●	●	●	○	○	○	○	○	○	○

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

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

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 child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child'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						

P101160700

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Well Child: 15 Months

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

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

IMMUNIZATIONS: DtaP (4th dose), Hep A (if 1st dose has not been given), Hib (3rd or 4th dose), Polio (if 3rd dose has not been given), MMR (if 1st dose has not been given), PCV 13 (if 4th dose not yet given)

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: 18 months

Talking and Feeling

- Try to give choices. Allow your child to choose between 2 good options, such as a banana or an apple, or 2 favorite books.
- Know that it is normal for your child to be anxious around new people. Be sure to comfort your child.
- Take time for yourself and your partner.
- Get support from other parents.
- Show your child how to use words.
  - Use simple, clear phrases to talk to your child.
  - Use simple words to talk about a book's pictures when reading.
  - Use words to describe your child's feelings.
  - Describe your child's gestures with words.

A Good Night's Sleep

- Put your child to bed at the same time every night. Early is better.
- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Try to tuck in your child when he is drowsy but still awake.
- Don't give your child a bottle in bed.
- Don't put a TV, computer, tablet, or smartphone in your child's bedroom.
- Avoid giving your child enjoyable attention if he wakes during the night. Use words to reassure and give a blanket or toy to hold for comfort.

American Academy of Pediatrics, "Bright Futures Parent Handout 15 Month – English," https://pediatrics.christieclinic.com/wp-content/uploads/2019/11/parent-handouts-15-month-english.pdf

Safety

▪ Make sure your child's car safety seat is rear facing until he reaches the highest weight or height allowed by the car safety seat's manufacturer. In most cases, this will be well past the second birthday.
▪ Never put your child in the front seat of a vehicle that has a passenger airbag. The back seat is the safest.
▪ Everyone should wear a seat belt in the car.
▪ Keep poisons, medicines, and lawn and cleaning supplies in locked cabinets, out of your child's sight and reach.
▪ Place gates at the top and bottom of stairs. Install operable window guards on windows at the second story and higher. Keep furniture away from windows.
▪ Turn pan handles toward the back of the stove.
▪ Don't leave hot liquids on tables with tablecloths that your child might pull down.
▪ Have working smoke and carbon monoxide alarms on every floor. Test them every month and change the batteries every year. Make a family escape plan in case of fire in your home.
▪ Put the Poison Help number into all phones, including cell phones. Call if you are worried your child has swallowed something harmful. Don't make your child vomit.
▪ IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222

Tantrums and Discipline:

▪ Use distraction to stop tantrums when you can.
▪ Praise your child when she does what you ask her to do and for what she can accomplish.
▪ Set limits and use discipline to teach and protect your child, not to punish her.
▪ Limit the need to say "No!" by making your home and yard safe for play.
▪ Teach your child not to hit, bite, or hurt other people.
▪ Be a role model.

Healthy Teeth:

▪ Take your child for a first dental visit if you have not done so.
▪ Brush your child's teeth twice each day with a small smear of fluoridated toothpaste, no more than a grain of rice.
▪ Wean your child from the bottle.
▪ Brush your own teeth. Avoid sharing cups and spoons with your child. Don't clean her pacifier in your mouth.

WHAT TO EXPECT AT YOUR CHILD'S 18 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