

# 12 Month Well Check-Up

Person completing form: Mother \_\_\_ Father \_\_\_ Grandparent \_\_\_  
Other \_\_\_\_\_

## Parental Concerns:

Do you have any concerns about your child's learning or development?  
Not At All  Somewhat  Very Much

Do you have any concerns about your child's behavior?

Not At All  Somewhat  Very Much

## Relationships:

Who lives in the home with the child? \_\_\_\_\_

Number of siblings? \_\_\_\_\_

Are you coping well with your child? No \_\_\_ Yes \_\_\_

Are you comfortable with your child? No \_\_\_ Yes \_\_\_

Over the past 2 weeks, have you felt down,  
depressed or hopeless? No \_\_\_ Yes \_\_\_

## Smokers:

Are there smokers at home? No \_\_\_ Yes \_\_\_

If yes, do they smoke outside only? No \_\_\_ Yes \_\_\_

## TB Risk Assessment:

Known exposure to person with TB? No \_\_\_ Yes \_\_\_

If yes, who? \_\_\_\_\_

## Home Environment & Safety:

Type of dwelling: (circle one) Apartment House Trailer Other

Heat source: (circle one) Gas Electric Hot water Other

Water source for dwelling: (circle one) City/municipal Well

Known Lead exposure in home? No \_\_\_ Yes \_\_\_

If yes, was it removed? No \_\_\_ Yes \_\_\_

Home built before 1950? No \_\_\_ Yes \_\_\_

Home built before 1978 with  
any home renovations in last 6 months? No \_\_\_ Yes \_\_\_

## Safety:

Infant car seat rear facing in vehicle? No \_\_\_ Yes \_\_\_

Does your dwelling have:

Carbon monoxide detectors? No \_\_\_ Yes \_\_\_

Smoke detectors? No \_\_\_ Yes \_\_\_

Pool/spa at home? No \_\_\_ Yes \_\_\_

Pets or animals at home? No \_\_\_ Yes \_\_\_

If yes, what types? \_\_\_\_\_

Firearms in the home? No \_\_\_ Yes \_\_\_

If yes, are they in locked storage? No \_\_\_ Yes \_\_\_

## Sleep Habits:

Any concerns? No \_\_\_ Yes \_\_\_

If yes, explain \_\_\_\_\_

Does your child take naps? No \_\_\_ Yes \_\_\_

Does your child sleep in bed with parents? No \_\_\_ Yes \_\_\_

Does your child sleep through the night? No \_\_\_ Yes \_\_\_

Does your child sleep 8 hrs or more per night? No \_\_\_ Yes \_\_\_

Any nightmares/night terrors? No \_\_\_ Yes \_\_\_

## Travel:

Any recent travel out of the country? No \_\_\_ Yes \_\_\_

If yes, where did you travel? \_\_\_\_\_

## Nutrition:

Does your child drink (circle all that apply) Milk Juice Water Soda

What type of milk is given?

Whole cow's \_\_\_ 2% \_\_\_ 1% \_\_\_ Soy \_\_\_ Almond \_\_\_ Rice \_\_\_

How many ounces of milk per day? \_\_\_\_\_

Does your child drink from a cup? No \_\_\_ Yes \_\_\_

Does your child drink from a bottle? No \_\_\_ Yes \_\_\_

Does your child still eat baby foods? No \_\_\_ Yes \_\_\_

Does your child eat table foods? No \_\_\_ Yes \_\_\_

## Dental:

Any concerns with child's teeth? \_\_\_\_\_

Brushing teeth every day? No \_\_\_ Yes \_\_\_

Using a pacifier? No \_\_\_ Yes \_\_\_

## Elimination:

Any concerns with urine output? No \_\_\_ Yes \_\_\_

Any concerns with bowel movements? No \_\_\_ Yes \_\_\_

## Illness/Injuries/Hospitalizations/Surgeries:

Since the last well visit, has your child:

Had any injuries or admitted to the hospital? No \_\_\_ Yes \_\_\_

Had any surgery? No \_\_\_ Yes \_\_\_

If yes, please explain \_\_\_\_\_

## Family History:

Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe \_\_\_\_\_

## Early Autism:

Does your child:

Point to objects? No \_\_\_ Yes \_\_\_

Respond to his/her name? No \_\_\_ Yes \_\_\_

Make eye contact with you? No \_\_\_ Yes \_\_\_

\*\*\* See Back of Form\*\*\*

## **Developmental Milestones**

	Not At All	Somewhat	Very Much
Picks up food and eats it.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulls up to standing.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plays games like "Peek-a-Boo," or "Pat-a-Cake" .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>
Calls you "mama," or "dada" or similar name .....	<input type="radio"/>	<input type="radio"/>	
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?" .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Copies sounds that you make.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walks across the room without help.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follows directions – like "Come here" or "Give me the ball"....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Runs .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walks up stairs with help.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>