

18 Month Well Check-Up

Person completing form: Mother ___ Father ___ Grandparent ___
Other _____

Parental Concerns:

Do you have any concerns about your child's learning 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? _____

Does your child attend daycare? No ___ Yes ___

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 ___

TB Risk Assessment:

Known exposure to person with TB? No ___ Yes ___

If yes, who? _____

Smoking:

Are there any smokers at home? No ___ Yes ___

If yes, do they smoke outside only? No ___ Yes ___

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 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 eat a healthy variety of
table foods? No ___ Yes ___

Dental:

Any concerns with child's teeth? _____

Brushing teeth every day? No ___ Yes ___

Has your child seen or are they scheduled to
see a dentist? No ___ Yes ___

Using a pacifier? No ___ Yes ___

Elimination:

Any concerns with urine output? No ___ Yes ___

Any concerns with bowel movements? No ___ Yes ___

Is your child potty training? 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 _____

See Back of Form

Developmental Milestones

	Not At All	Somewhat	Very Much
Runs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walks up stairs with help.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kicks a ball	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Names at least 5 familiar objects – like ball or milk.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Names at least 5 body parts – like nose, hand, or tummy.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbs up a ladder at a playground.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uses words like “me” or “mine”....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jumps off the ground with two feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Puts 2 or more words together – like “more water” or “go outside”.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uses words to ask for help.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Parent’s Observations of Social Interactions (POSI)

Does your child bring things to show them to you?

Many Times a Day A Few Times a Day A Few Times a Week Less Than Once a Week Never

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you say a word or wave your hand, will your child try to copy you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look at you when you call his or her name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look if you point to something across the room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(Please check all that apply)

Does your child **Usually** show you something he or she wants?

Says a word for Points to it Reaches for Pulls me over or Grunts, cries or
 for what he/she wants with one finger for it puts my hand on it screams

What are your child’s favorite play activities?

Playing with dolls or Reading books Climbing, running and Lining up toys or Watching things go round and
 Stuffed animals with you being active other things round like fans or wheels

