15 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 build 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____

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 Screening:
Does your child:
Point to objects? Yes____No____
Respond to his/her name? Yes____No____
Make eye contact with you? Yes____No____

See Back of Form

Developmental Milestones

	Not At All	Somewhat	Very Much
Calls you “mama,” or “dada” or similar name……	○	○	○
Looks around when you say things like “Where’s your bottle?” or “Where’s your blanket?”……..	○	○	○
Copies sounds that you make……..	○	○	○
Walks across the room without help …..…	○	○	○
Follows directions- like “Come here” or “Give me the ball”…….	○	○	○
Runs……	○	○	○
Walks up the stairs with help……..	○	○	○
Kicks a ball……..	○	○	○
Names at least 5 familiar objects – like ball or milk…….…	○	○	○
Names at least 5 body parts – like nose, hand, or tummy……..	○	○	○