Name: _____ Date of birth: _____

Health Status Questionnaire – 18 Months

Child lives with: mother father both parents other:_____

Childcare: daycare babysitter stays at home other:_____

Feedings:
__ cup __ bottle(should be weaned) __ breast __ solid foods __ meals __ snacks
whole milk: <16oz/day 16-24oz/day 24-30oz/day >30oz/day
__ picky eater __ prefers milk __ no water __ lots of juice

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Development concerns: none speech motor social cognitive vision hearing

Does your child:

Try to run?	Y	N
Walk backwards?	Y	N
Kick a ball?	Y	N
Throw a ball?	Y	N
Stack 2 blocks/items?	Y	N
Scribble?	Y	N
Follow simple commands?	Y	N
Say 4-10 words?	Y	N
Point to things he/she want?	Y	N
Try to use spook/fork?	Y	N
Remove clothing?	Y	N
Imitate housework?	Y	N

Car seat use:	Y	N	Smoke detectors:	Y	N
Sunscreen:	Y	N	Fire extinguishers:	Y	N
Insect protection:	Y	N	Firearms/guns in house:	Y	N
Home child proofed:	Y	N	Locked away:	Y	N
Dental visit:	Y	N	Passive smoke exposure:	Y	N

(continue on back)

M-CHAT-R (autism screen):

1. If you point at something across the room, does your child look at it?
   (if you point at a toy, does your child look at the toy?) Y N
2. Have you ever wondered if your child might be deaf? Y N
3. Does your child play pretend or make-believe? (pretend to drink from cup,
   talk on phone or feed a doll or stuffed animal?) Y N
4. like climbing on things like furniture, playground equipment or stairs? Y N
5. Does your child make unusual finger movements near his/her eyes?
   (wiggle his/her fingers close to his/her eyes?) Y N
6. Does your child point with one finger to ask for something or to get help?
   (pointing to a snack or toy that is out of reach) Y N
7. Does your child point with one finger to show you something interesting?
   (pointing to airplane in the sky or big truck in the road) Y N
8. interested in other children?(watch other children, smile at them or go to them) Y N
9. show you things by bringing them to you or holding them up for you
   to see-not to get help, but just to share?(showing you flower or toy) Y N
10. Does your child respond when you call his or her name?
    (look up, talk or babble, or stop what he/she is doing when called) Y N
11. When you smile at your child, does he/she smile back at you? Y N
12. get upset by everyday noises? (scream/cry to vacuum cleaner/loud music) Y N
13. Does your child walk? Y N
14. look you in the eye when you are talking to, playing with or dressing him/her? Y N
15. copy what you do?(like wave bye-bye, clap or make funny noise) Y N
16. If you turn your head to look at something, does your child look
    around to see what you are looking at? Y N
17. Does your child try to get you to watch him/her?
    (look at you for praise, or say "look" or "watch me") Y N
18. understand when you tell him/her to do something? (if you don't point,
    can he/she understand "put the book on the chair"/ "bring me the blanket") Y N
19. If something new happens, does he/she look at your face to see how you feel
    about it?(if hears a strange/funny noise, or see new toy, look at your face) Y N
20. like movement activities? (being swung or bounced on your knee) Y N

Do you have any concerns about your child? _____

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