



Bright Futures Parent Handout 12 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

Family Support

FAMILY SUPPORT

- Try not to hit, spank, or yell at your child.
- Keep rules for your child short and simple.
- Use short time-outs when your child is behaving poorly.
- Praise your child for good behavior.
- Distract your child with something he likes during bad behavior.
- Play with and read to your child often.
- Make sure everyone who cares for your child gives healthy foods, avoids sweets, and uses the same rules for discipline.
- Make sure places your child stays are safe.
- Think about joining a toddler playgroup or taking a parenting class.
- Take time for yourself and your partner.
- Keep in contact with family and friends.

Establishing Routines

ESTABLISHING ROUTINES

- Your child should have at least one nap. Space it to make sure your child is tired for bed.
- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Avoid having your child watch TV and videos, and never watch anything scary.
- Be aware that fear of strangers is normal and peaks at this age.
- Respect your child's fears and have strangers approach slowly.
- Avoid watching TV during family time.
- Start family traditions such as reading or going for a walk together.

Feeding Your Child

FEEDING AND APPETITE CHANGES

- Have your child eat during family mealtime.
- Be patient with your child as she learns to eat without help.
- Encourage your child to feed herself.
- Give 3 meals and 2–3 snacks spaced evenly over the day to avoid tantrums.
- Make sure caregivers follow the same ideas and routines for feeding.
- Use a small plate and cup for eating and drinking.
- Provide healthy foods for meals and snacks.
- Let your child decide what and how much to eat.
- End the feeding when the child stops eating.
- Avoid small, hard foods that can cause choking—nuts, popcorn, hot dogs, grapes, and hard, raw veggies.

Safety

SAFETY

- It is best to keep your child's car safety seat rear-facing until she reaches the seat's weight or height limit for rear-facing use. Do not switch your child to a forward-facing car safety seat until she is at least 1 year old and weighs at least 20 pounds. Most children can ride rear-facing for much longer than 12 months.
- Lock away poisons, medications, and lawn and cleaning supplies. Call Poison Help (1-800-222-1222) if your child eats nonfoods.
- Keep small objects, balloons, and plastic bags away from your child.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Lock away knives and scissors.

SAFETY

ESTABLISHING A DENTAL HOME

- Only leave your toddler with a mature adult.
- Near or in water, keep your child close enough to touch.
- Make sure to empty buckets, pools, and tubs when done.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.

Finding a Dentist

- Take your child for a first dental visit by 12 months.
- Brush your child's teeth twice each day.
- With water only, use a soft toothbrush.
- If using a bottle, offer only water.

What to Expect at Your Child's 15 Month Visit

We will talk about

- Your child's speech and feelings
- Getting a good night's sleep
- Keeping your home safe for your child
- Temper tantrums and discipline
- Caring for your child's teeth

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Name: _____

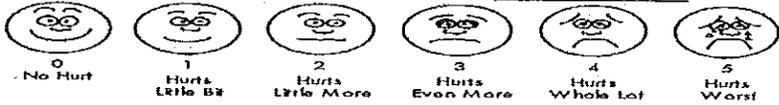
FMP and Sponsor Last Four: _____ / _____

Date: _____

(Patient Label)

If this is the **FIRST** time you are filling in this form, please complete **ALL** areas.
If you have **ALREADY** completed it, please complete **SHADED** areas **ONLY**.

1. **No Allergies** Please list any allergies you have (drug, food, latex) _____

Clinic Use Only					
BP	/	HT		Visual Acuity: R 20/____ L 20/____ Both 20/____	
HR		WT		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____	
RR		HC			
TEMP		SpO2			

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates) (Circle all that apply)	Family History—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)	Medicines (PLEASE INCLUDE DOSAGE)
NO Medical Conditions Asthma Diabetes Hayfever/Allergies Other: _____	NO History of Surgeries Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other: _____	Birth Defects Deafness before Age 5 Kidney Disease Post Partum Depression Early or Sudden Death to include SIDS Heart attack before age 50 High Blood Pressure High Cholesterol Hypertrophic Cardiomyopathy Long QT syndrome Arrhythmias Diabetes Mental Illness Alcohol or Substance Abuse Genetic or Metabolic Disease Other: _____	Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter <input type="checkbox"/> Infant Multivitamin 1 ml per day

BIRTH HISTORY-Complete for AGES NEWBORN TO 2 YEARS

Place of Birth: _____
 Birth weight? _____ # weeks pregnant at delivery? _____
 Prenatal complications No Yes describe: _____
 Group B Strep. (GBS) Positive Negative Don't Know
 Type of Delivery (check all that apply):
 Vaginal Forceps Vacuum-assisted C-section Breech
 Complications at birth?
 Jaundice * Yes No Phototherapy * Yes No Hip Click/Clunk * Yes No
 Other: _____
 Did your child receive the Hepatitis B vaccine at birth? Yes No Unsure

Newborn Metabolic Screen Submitted:
 Yes No Don't Know
 Repeated
 Baby's Hearing Screen:
 Passed Bilateral
 Repeat Needed
 Don't Know

 Clinic Use Only - For Newborns-2 weeks
 Complete Risk assessment for Jaundice
 (Bill and Blood Type)

Source of Medical Information: Mother Father Patient Other: _____
 Any Hospitalizations, specialty care, or ER visits since your last appointment? No Yes:
 Would you say your child's Overall Feeling of health is? Excellent Very Good Good Fair Poor
 Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid? Yes No Decline
 Are your child's immunizations up to date? Yes Unsure No

Does your child have a chronic medical or behavioral health problem, and/or physical disability? No Yes
 Is frequent follow-up support required for the above issues? No Yes
 Does your child require early interventions or special education services? No Yes
 Is your child enrolled in the Exceptional Family Member Program? No Yes

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

Is your child In Day-Care
 Does anyone in the family smoke or is your child exposed to secondhand smoke? No Yes
 Who does the Child Live With? Parents Mother Father Other:
 Is Sponsor currently deployed: No Yes
 Is this visit deployment related: No Yes
 Does your child ride in a car with a car seat? Yes No

Tuberculosis Screening - Complete at 1, 6, 12, and 18 month Well Child Visit
 Yes No Unsure Has a family member or contact had tuberculosis?
 Yes No Unsure Has a family member had a positive tuberculin skin test?
 Yes No Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, or Western Europe)?
 Yes No Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

Lead Screening - Complete at 6, 9, 12, and 18 Month Well Child Visit
 Yes No Unsure Does your child have a sibling or playmate with Hx of lead poisoning?
 Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1950?
 Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

What is your preferred method for learning: Verbal Written Visual Hands-On Other: _____
 Yes No - Do you or your child have learning/readiness needs?
 Yes No - Are there cultural or religious considerations that affect your child's healthcare?
 Yes No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?
****PLEASE PROVIDE A GOOD CONTACT NUMBER: _____**

Breastfeeding? Yes No How often? _____ Minutes per breast? _____ Concerns? _____
 Bottle feeding? Yes No Brand? _____ Ounces per feed? _____ How often? _____
 Number of wet diapers per day? _____ Stools per day? _____
 Circle if you have any concerns about the following (circle all that apply): Bowel movements / Constipation / Sleep problems

If Edinburgh Postpartum Depression Screen (EPDS) not attached.
 Mother please complete below questionnaire at 1week, 2 and 4 month Well Child visits.

Over the last 2 weeks, how often have you been bothered by any of the following?
 Little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day
 Feeling depressed or hopeless? Not at all Several days More than half the days Nearly every day

------(This section NOT for patient use)-----

Treatments orders for this visit - Ensure Patients Name and last four on Front of Document:

<input type="checkbox"/> Flu Swab	<input type="checkbox"/> Ear Irrigation	<input type="checkbox"/> CBC	<input type="checkbox"/> Chol Panel	<input type="checkbox"/> Bilirubin (T/D)	<input type="checkbox"/> CXR
<input type="checkbox"/> RSV Swab	Left --- Right	<input type="checkbox"/> UA	<input type="checkbox"/> HbA1c	<input type="checkbox"/> TsBill	<input type="checkbox"/> EKG
<input type="checkbox"/> Strep Screen/TCx	<input type="checkbox"/> Saline Bulb Suction	<input type="checkbox"/> CRP/ESR	<input type="checkbox"/> TSH, T4	<input type="checkbox"/> Monospot	
<input type="checkbox"/> Tussin Swab	<input type="checkbox"/> Motrin (PO) _____ mg	<input type="checkbox"/> BMP	<input type="checkbox"/> Iron Profile	<input type="checkbox"/> EBV Titers	
<input type="checkbox"/> Dex	<input type="checkbox"/> Tylenol (PO) _____ mg	<input type="checkbox"/> CMP	<input type="checkbox"/> Lead		
<input type="checkbox"/> EVALUATE FOR VACCINE UPDATE	<input type="checkbox"/> PPD	<input type="checkbox"/> Other			

Immunizations - 2 Month - Pediarix (DTaP-IPV-HepB), Hib, PCV-13, Rotateq

Well Child Developmental Screenings		
1 Week (3-5 days)	1 MONTH	2 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Eats well	<input type="checkbox"/> If upset, able to calm	<input type="checkbox"/> Lifts head and begins to push up when prone
<input type="checkbox"/> Follows your face	<input type="checkbox"/> Has started to smile	<input type="checkbox"/> Holds head erect for short period (when held upright)
<input type="checkbox"/> Turns and calms to your voice	<input type="checkbox"/> Recognizes voice of parents	<input type="checkbox"/> Diminished newborn reflexes
<input type="checkbox"/> Can suck, swallow and breath easy	<input type="checkbox"/> Follows parents with eyes	<input type="checkbox"/> Symmetrical movements
	<input type="checkbox"/> Able to lift head when on tummy	<input type="checkbox"/> Indicates boredom when no activity change
		<input type="checkbox"/> Coos
		<input type="checkbox"/> Different crying for different needs
		<input type="checkbox"/> Smiles
		<input type="checkbox"/> Looks for parents
		<input type="checkbox"/> Self-comfort
4 MONTH	6 MONTH	9 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)***
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Pushes chest to elbows	<input type="checkbox"/> Sits briefly, leaning forward	<input type="checkbox"/> Sits well
<input type="checkbox"/> Good Head control	<input type="checkbox"/> Rolls over	<input type="checkbox"/> Crawls
<input type="checkbox"/> Symmetry in movements	<input type="checkbox"/> Uses visual exploration	<input type="checkbox"/> Pulls to feet with support
<input type="checkbox"/> Begins to roll and reach for objects	<input type="checkbox"/> Beginning to use oral exploration	<input type="checkbox"/> Peekaboo
<input type="checkbox"/> Responds to affection	<input type="checkbox"/> Uses a string of vowels (ah, eh, oh)	<input type="checkbox"/> Objects permanence
<input type="checkbox"/> Indicates pleasure of displeasure	<input type="checkbox"/> Beginning to recognize own name	<input type="checkbox"/> Looks at book
<input type="checkbox"/> Spontaneous expressive babbling	<input type="checkbox"/> Enjoys vocal turn taking	<input type="checkbox"/> Imitates sounds
<input type="checkbox"/> Social smile	<input type="checkbox"/> Shows pleasure from interaction with parents or others	<input type="checkbox"/> Points out objects
<input type="checkbox"/> Elicits social interactions		<input type="checkbox"/> Stranger anxiety
<input type="checkbox"/> Smiles spontaneously		<input type="checkbox"/> Seeks parent for comfort
<input type="checkbox"/> Can calm down on own		
12 MONTH	15 MONTH	18 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)***
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Waves bye-bye	<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house
<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house	<input type="checkbox"/> Laughs in response to others
<input type="checkbox"/> Cries when you leave	<input type="checkbox"/> Listens to a story	<input type="checkbox"/> Speaks 6 words
<input type="checkbox"/> Plays Peekaboo	<input type="checkbox"/> Says 2 to 3 words	<input type="checkbox"/> Knows names of favorite books
<input type="checkbox"/> Hands you a book to read	<input type="checkbox"/> Scribbles	<input type="checkbox"/> Points to 1 body part
<input type="checkbox"/> Speaks 1-2 words	<input type="checkbox"/> Follows simple commands	<input type="checkbox"/> Stacks 2 small blocks
<input type="checkbox"/> Babbles	<input type="checkbox"/> Bends down without falling	<input type="checkbox"/> Runs
<input type="checkbox"/> Tries to make the same sounds you do	<input type="checkbox"/> Walks well	<input type="checkbox"/> Walk up steps
<input type="checkbox"/> Looks at things you are looking at	<input type="checkbox"/> Puts blocks in a cup	<input type="checkbox"/> Uses spoon and cup without spilling most of the time
<input type="checkbox"/> Follows simple directions	<input type="checkbox"/> Puts block in a cup	
<input type="checkbox"/> Bangs toys together	<input type="checkbox"/> Drinks from cup with very little spilling	

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE _____ SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

AHLTA was not accessible during this patient visit. Reviewed note & agree _____ (Provider Initial)

- VISIT FOR: : Acute Well Child Visit 3-5 day/1 week 1 Month 2 Months 4 Months
 6 Months 9 Months 12 Months 15 Months 18 Months

HPI:

ROS: Check only symptoms that may apply to today's visit.

<input type="checkbox"/> Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Poor Weight Gain
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hearing Concerns
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Earache	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Pulling at the Ear(s)	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Snoring
<input type="checkbox"/> Eyes Discharge	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Rash	<input type="checkbox"/> Excessive Thirst

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/AFOF/neck supple	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> EOMI, RR X2, NI corneal reflex <input type="checkbox"/> no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, NI WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, <input type="checkbox"/> no sacral dimple	<input type="checkbox"/> Sacral Dimple
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/> Jaundice
<input type="checkbox"/>	Hips:	<input type="checkbox"/> Full ROM, <input type="checkbox"/> Neg Barlow <input type="checkbox"/> Neg Ortolani	<input type="checkbox"/> Hip click <input type="checkbox"/> Hip clunk
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia:	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down B/L	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS: Hip U/S Spine U/S

A/P : Well baby: normal growth & development for age
 400 IU Vitamin D supplement/day Infant Multivitamin 1 ml per day Triple paste to diaper area Q diaper change

F/U: at next well child visit at ___ months, or sooner if parental concerns

- Patient and/or parent verbalizes understanding of treatment and plan
 Anticipatory guidance/Prevention handout provided



12 Month ASQ-3 Information Summary

11 months 0 days through
12 months 30 days

Baby's name: _____ Date ASQ completed: _____
 Baby'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	15.64		<input type="radio"/>												
Gross Motor	21.49		<input type="radio"/>												
Fine Motor	34.50		<input type="radio"/>												
Problem Solving	27.32		<input type="radio"/>												
Personal-Social	21.73		<input type="radio"/>												

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

- | | | | | | |
|--|------------|-----------|--|-----|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Plays with sounds or seems to make words?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Concerns about not making sounds?
Comments: | YES | No | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
Comments: | YES | No | | | |

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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.

If the baby'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						



Ages & Stages Questionnaires®

12 Month Questionnaire

11 months 0 days through 12 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.



Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender:
 Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby:
 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

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

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

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	___
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When your baby wants something, does he tell you by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

GROSS MOTOR

1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?

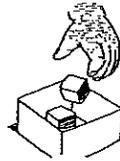


2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?
3. Does your baby walk beside furniture while holding on with only one hand?

	YES	SOMETIMES	NOT YET	___
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|----|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? (If she already lets go of the toy into a bowl or box, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? (You may show him how to do it.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —* |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? (If she already scribbles on her own, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

**PROBLEM SOLVING TOTAL**

*If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? (If he already lets go of the toy into your hand, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

PERSONAL-SOCIAL TOTAL

GROSS MOTOR (continued)

4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.)



YES SOMETIMES NOT YET

5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.)



6. Does your baby stand up in the middle of the floor by himself and take several steps forward?

GROSS MOTOR TOTAL _____

FINE MOTOR

1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be attached to a toy.)



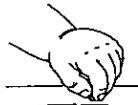
YES SOMETIMES NOT YET

2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it.



3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?

4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?



 _____*

5. Does your baby throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)



6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.)

FINE MOTOR TOTAL _____

*If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

 YES NO

2. Does your baby play with sounds or seem to make words? If no, explain:

 YES NO

3. When your baby is standing, are her feet flat on the surface most of the time?
If no, explain:

 YES NO

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain:

 YES NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

 YES NO

OVERALL (continued)

6. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

7. Has your baby had any medical problems in the last several months? If yes, explain:

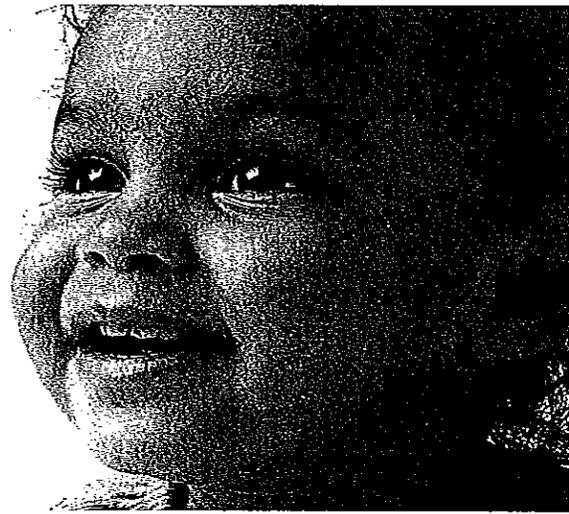
 YES NO

8. Do you have any concerns about your baby's behavior? If yes, explain:

 YES NO

9. Does anything about your baby worry you? If yes, explain:

 YES NO



Questions about your child's development?

Educational & Developmental Intervention Services (EDIS)

is a program for infants and toddlers (birth to 36 months) who have:

- medical conditions which may affect development (such as complications of prematurity, hearing or visual impairment)
- developmental delay (for example, not walking or talking as expected) or atypical development
- genetic conditions

Educational & Developmental Intervention Services provides:

- in-home services
- basic services are free to eligible children:
 - * developmental evaluation (includes physical, communication, problem-solving, self-help, and social-emotional skills)
 - * in-home training for parents on encouraging child's development
 - * service coordination (helps parents access other services)

Parents can refer their children!

To make a referral, call:

(for families living on base:)

**Educational & Developmental
Intervention Services**
Location: 5400 Florida Avenue
Berkeley Manor Housing Area
Mailing Address:
EDIS
5400 Florida Avenue
Camp Lejeune, NC 28547
910 450 4127

(for families living off base:)

Children's Developmental Services Agency
2842 Neuse Blvd
New Bern, NC 28562
866 KIDS N NC (toll free)
866 543 7662