Today's Date:_____

Patient Name:	FMP and Sponsor SSN last four:	Contact Number: Date of Birth:

18 MONTH WELL CHECK

Do you have any specific concerns today?_____

_____

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

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medications (PLEASE INCLUDE DOSAGE)
		Allergies **Asthma** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):**

Please list any known allergies your child has (drug, food, latex)_____ □ **No Allergies**

Circle if anyone in the family has had: Genetic or Metabolic Disease Kidney Disease Deafness before age 5

Birth Defects Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Are your child's immunizations up to date? □ Yes □ No

Who does the child live with? _____

Does your child attend daycare? □ Yes □ No

Does anyone in the family smoke or is your child exposed to secondhand smoke? □ Yes □ No

Do you & and your child feel safe at home? □ Yes □ No

Breastfeeding? □ Yes □ No **How often**_____**Minutes per breast**_____**Concerns**_____

Formula feeding? □ Yes □ No **Brand**_____**Ounces per feed**_____**Ounces per day** _____

Drinks whole milk? □ Yes □ No **Ounces per day** ____ **Drinks Juice** □ Yes □ No **Ounces per day** _____

Good variety of table foods? □ Yes □ No

Circle if you have concerns about: Bowel movements / Constipation / Sleep problems

Check all the following that apply to your child:

Social/ Cognitive Communicative/ Physical Development	
□ Points to body parts	□ Starting to run
□ Helps with simple tasks	□ Uses spoon (utensils) to eat
□ Plays pretend or copies activities (ex: Feeds doll)	□ Uses 6 or more words regularly
□ Points to show something of interest	

Preferred Language: □ English □ Other:_____

What is your preferred method of learning: □ Verbal □ Written□ □Visual□ □ Other: _____

Are there any cultural or religious considerations that may affect your child's healthcare? □ Yes □ No _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/ Q-coded)? □ Yes □ No

Is the child's sponsor currently deployed? □ Yes □ No

Is this visit deployment related? □Yes □ No

Today's Date:_____

HR		**LT**	
		Naked WT	
		HC	

Pain: □ **Yes** □ **No** **Location of Pain** _____

USE FLACC SCALE FOR NON-VERBAL CHILDREN

Immunizations UTD per AFCITA: □ Yes □ No **Technician Signature:**_____

*Other VS per Provider request

HPI:

N E	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT/Nontender/FROM	□
□	**Eyes:**	□ RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions □ Teeth: Nl, no signs of caries	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong femoral pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no mass, nl BS, no umbilical/inguinal hernia	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, no lumbosacral pits	□
□	**Skin:**	□ No rash, No bruises	□
□	**Hips:**	□ Full ROM, Symmetric leg folds	□
□	**Neuro:**	□ Normal tone/strength/symmetry	□
□	**Genitalia:**	□ Nl female/no adhesions □ Nl male, Testes down	
□	**Other findings:**	□	□

LABS/X-RAYS: □ H&H (12 months): □ Lead Screening (if applicable)

PLAN:

F/U: at next well child visit at___months, sooner if parental concerns
□ Patient and/or parent verbalizes understanding of treatment and plan □ Anticipatory guidance handout provided

PREVENTION: □ Nutrition □ Sippy Cups/No Bottle □ Dental care □ Safety/Falls □ Car Seat □ Child-proofing the house □ Tobacco avoidance

Signature:_____**Date:**_____
Stamp:

23 Jan 2012 SF 600

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

STANDARD FORM 600 Overprint

ASQ-3 Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 months 30 days

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

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

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

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ 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

Child ID #:

Age at administration, in months and days: M M D D

Program ID #:

If premature, adjusted age, in months and days: M M D D

Program name:

E101180100

ASQ-3

18 Month Questionnaire

17 months 0 days through 18 months 30 days

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

Important Points to Remember:

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

Notes:

_____

_____

_____

_____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by *pointing* to it?	○	○	○	—
2. When you ask your child to, does he go into another room to find a familiar toy or object? *(You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")*	○	○	○	—
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	○	○	○	—
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? *(Mark "yes" even if her words are difficult to understand.)*	○	○	○	—
5. Without your showing him, does your child *point* to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(He needs to identify only one picture correctly.)*	○	○	○	—
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? *(Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")* Please give an example of your child's word combinations:	○	○	○	—

COMMUNICATION TOTAL —

E101180200

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	○	○	○	___
2. Does your child move around by walking, rather than by crawling on her hands and knees?	○	○	○	___
3. Does your child walk well and seldom fall?	○	○	○	___
4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___
5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	○	○	○	___
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)* 	○	○	○	___

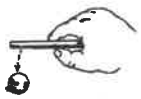
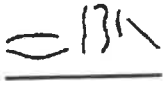
GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	___
2. Does your child stack a small block or toy on top of another one? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	○	○	○	___
4. Does your child stack three small blocks or toys on top of each other by himself?	○	○	○	___
5. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	○	○	○	___
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your child drop several small toys, one after another, into a container like a bowl or box? *(You may show him how to do it.)*	○	○	○	—
2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? 	○	○	○	—
3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? *(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)*	○	○	○	—
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	○	○	○	—
5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in *any direction*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	○	○	○	—
6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? *(Do not show him how.)*	○	○	○	—*

PROBLEM SOLVING TOTAL —

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While looking at herself in the mirror, does your child offer a toy to her own image?	○	○	○	—
2. Does your child play with a doll or stuffed animal by hugging it?	○	○	○	—
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	○	○	○	—
4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar?	○	○	○	—
5. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	—
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	—

PERSONAL-SOCIAL TOTAL —

E101180400

OVERALL

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

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other toddlers his age? If no, explain: ○ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain: ○ YES ○ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

6. Do you have concerns about your child's vision? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

8. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

9. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

ASQ-3 18 Month ASQ-3 Information Summary

17 months 0 days through 18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child'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	13.06		●	●	●	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Gross Motor	37.38		●	●	●	●	●	●	●	●	◯	◯	◯	◯	◯
Fine Motor	34.32		●	●	●	●	●	●	●	◯	◯	◯	◯	◯	◯
Problem Solving	25.74		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Personal-Social	27.19		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯

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

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

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 child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▬ area, it is close to the cutoff. Provide learning activities and monitor.
If the child'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						

P101180700

Well Child Visit: 18 Months

General Pediatrics Department, Naval Medical Center Portsmouth
After Hours Pediatric Advice Line 953-7716 **Poison Control** 1-800-222-1222
Appointments or Referrals 1-866-MIL-HLTH **How do I call my doctor?** 953-7716
Up-to-the-minute health information specially customized for you and your family: www.healthychildren.org

Date: _____ **Your child saw Dr.** _____ **today**

Weight: _____**kg (** _____**%)** _____ **lbs** _____ **oz**
Length: _____**cm (** _____**%)** _____ **inches** **Head Circ:** _____**cm (** _____**%)**

Caring for your young child:

Dental Care: Brush your child's teeth twice a day with a soft toothbrush and water only. To prevent cavities, avoid frequent snacks, sugary drinks, and provide no more than 4 ounces of juice daily. Your child should drink only from a cup. If your child has not seen the dentist, make an appointment now.

Stick to a bedtime routine: Create a consistent bedtime routine with a "wind down" time before bed. Give your child a bath, cuddle, read a book and put your child to sleep. No bottles in bed! Children at this age should sleep through the night. If your child wakes up at night and cries, check to see that your child is safe, and allow your child to put him or herself back to sleep. If your child wanders into your bedroom, quietly return him or her to their own bed.

Meal times: Offer three meals daily and healthy snacks in between. Have your child sit in a highchair while eating. Do not allow walking around, running or excitement during meal time. Encourage your child to feed him or herself with fingers or a spoon. If your child is a picky eater, keep serving sizes small, and continue to offer new foods.

Self-soothing behavior: Many normal young children will engage in thumb sucking, ear pulling, hair pulling, and head banging at this age. Thumb sucking will not harm your child's teeth at this age.

Smoking: Second-hand smoke causes a greater risk for ear infections, chronic stuffy noses, SIDS, asthma and respiratory infections. Second-hand smoke lingers on clothes and everywhere a person has smoked (in the house/car). Never smoke while holding your child. For your child's health, if you smoke, consider quitting.

Development and your young child: Over the next 3-6 months, you can expect your child to

- Say about 30-50 words, put two and three words together, name everything that he or she sees often, and ask many questions, such as "why?" and "what's that?"
- Walk, run, climb, kick a ball, turn a door knob to open a door, and walk up and down stairs without help
- Have difficulty sharing; sometimes show anger by slapping, kicking or biting
- Will start to use one hand more than the other for tasks, demonstrating handedness
- Point to seven body parts and make a tower of eight blocks
- Begin to use crayons with more control besides just scribbling
- Play with a doll or stuffed animal by "taking care of it"- feeding it, rocking it, hugging it

Playtime:

- Great toys at this age are blocks to stack, cans, boxes, balls, simple puzzles, pots and pans, and books with hard pages.
- Read to your child everyday. Point and name all the objects in a book. Your child will begin to mimic these words, and will recognize the pictures.
- Your child will enjoy chase-me, catch-me and find-me games.
- Your child will enjoy copying and mimicking your activities- cleaning, driving, and talking on the phone
- Television is not a good babysitter, and is not recommended for children under age 2. When your child does watch television, talk about what he or she is watching.

Safety:

1. **Falls and injuries:** Falls cause many injuries in mobile children. Use secure gates at the top and bottom of stairways. Use guards on windows. Use safety latches on cabinets and drawers. Keep sharp objects in a secure place. Keep a constant close eye on your child.
2. **Choking**: Avoid toys with small parts that can fall out/off or be removed. Avoid small hard foods like peanuts, popcorn, whole grapes or hotdogs. Keep balloons, coins, plastic bags, and medications out of the reach of your small child. Your child will place any and all things in their mouth. Keep window blinds and curtain cords out of reach- these can strangle young children.
3. **Burns:** Never leave cups of hot liquids on table/counter edges. Use your smoke alarm and check it monthly. Place your child in a highchair, crib or playpen when cooking. Do not leave a hot iron accessible with a dangling cord.
4. **Car accidents**: Your child should always ride in a properly-installed car seat, even on short trips. The safest place for a car seat is in the back seat, facing the rear of the car until your baby is **2 years of age, or until outgrowing the rear-facing guidelines for the car seat.** Be a good example and always wear your seatbelt in the car. Never leave your child alone in the car, not even for "just a second."
5. **Sun**: Keep your child in the shade when possible, and keep his/her head covered with a hat. Use sunscreen on sun exposed areas, avoiding the hands.
6. **Drowning:** Never leave your child alone, or in the care of another small child, *in or near* a bathtub, toilet, bucket of water, swimming pool, or at the beach. Learn CPR.
7. **Poisoning:** Many things can poison children. Watch out for garden and house plants, hair products and cosmetics, and gasoline, insecticides, and cleaning products.

This is a challenging time for many parents! :

- Your child will explore everything, and needs to explore in order to learn. Your child does not know that this exploring can be dangerous or cause accidents. Talk to your doctor about creating safe home for your child to explore. Anticipate that you or a caregiver will ***need to keep a close eye on your child at all times.***
- Set reasonable limits for the safety of your child. You can use a verbal "no," distract, or remove objects from your child's sight. Never use physical punishment.
- Use serious punishment only for misbehavior where real danger exists. Avoid slapping hands or spanking. Use a 1-2 minute time out, choosing a location that is dull, but safe and non-frightening.
- ***Be consistent!*** All caregivers should discuss and agree on what is acceptable and unacceptable behavior.
- Young children have short memories and may repeat a behavior several times before they learn.
- Praise good behavior, such as "I like it when you help me pick up your toys." Don't give rewards after tantrums.
- Remember to take time for yourself.

Illness concerns:

- **Fever:** Fever is a common reason for bringing young children to the emergency room or clinic. If your child has a fever, but is otherwise acting well, you may give your child Tylenol or Motrin. Both viral and bacterial infections can cause a high fever. The temperature of a child with a fever is less concerning than how the child is behaving overall. If a fever lasts for more than 48-72 hours, but your child is still well appearing, call the clinic for further guidance.
- **Use of the emergency room(ER):** Your young child should be brought to the ER if he/she does not look well, is unusually sleepy or inconsolable, is vomiting persistently or excessively, vomits anything green or bloody, is working hard to breathe, is dehydrated or has less than one wet diaper every 6-8 hours, or for other parental concerns.

Immunizations

Your child will receive the DTaP and Hepatitis A vaccines today. The Influenza vaccine is recommended for all children over six months of age during Flu season.

Next Visit

Bring your baby in at 24 months of age for an exam and vaccinations. Always bring your child's immunization card to the clinic. Schedule your appointment 3-6 weeks in advance. Arrive 15 minutes before your appointment for check-in.

NAVAL MEDICAL CENTER PORTSOUTH
PATIENT CLINICAL SUMMARY /CHECKOUT FORM
CLINIC PHONE NUMBER: (757)-953-7716

Today you were seen by _____

☐ **Medications** in the pharmacy (2ND Floor). **(Hours Mon-Fri 7:30 a.m. – 9 p.m., Sat 7:30 a.m. – 5 p.m., Sun 9 a.m. – 5 p.m.)**

- o _____
- o _____
- o _____

☐ **Laboratory, 1 st Floor North (Hours are 0630-1600)**

☐ **Radiology, 1st Floor South (Hours 0730-1600, Call 953-XRA Y to schedule for Ultrasound/CT/MRI)**

If do not receive a call with your lab or radiology exam results within a week, please email us using Secure Networking or call the clinic

☐ **In-House Specialist Referral,** Call 1-866-645-4584 (in 48 - 72 hours) to schedule your appointment.

- o _____

☐ For **TRI CARE Network** Approved Referrals or additional **TRI CARE Issues** please call 1-800-444-5445. *if you are not given an appointment scheduled within 28 days from date of any referral, please let us know*

☐ Feel free to call TRICARE or go to www. militaryonesource.com for other health needs like:

- o Counseling (12 sessions without referral); **24 hour hotline number: 1-800-342-9647.**
- o Optometry
- o Other: _____

☐ Go to: Immunizations **(2nd Floor, Behind Gift Shop)**

☐ Follow-up with your provider in _____or if your condition does not improve.

☐ Additional Instructions: _____

_____

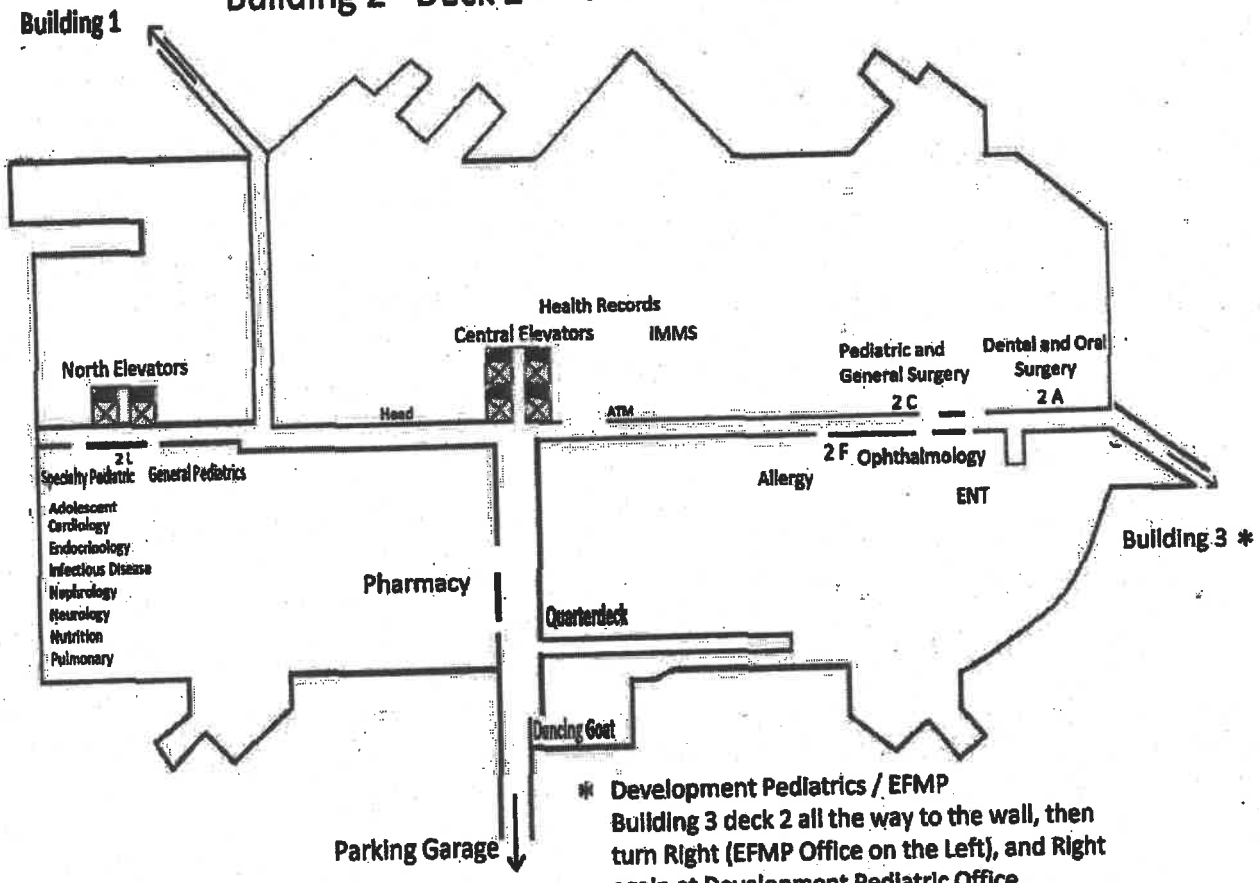
_____

Important Phone Numbers:

- Appointment Line: (866)-645-4584
- 24 hour Counseling Self-Referral Hotline: (800)-342-9647
- Infant and Toddler Connection of Virginia: (800)-234-1448
- Nurse Advice Line: (800)-TRICARE (option#1)
- Poison Control: (800)-222-1222
- Humana East Information: (800)-444-5445
- X-RAY: (757)-953-XRAY
- Humana Military:https://www.humana.com
- Secure Messaging: Identity.tolsecuremessaging.com

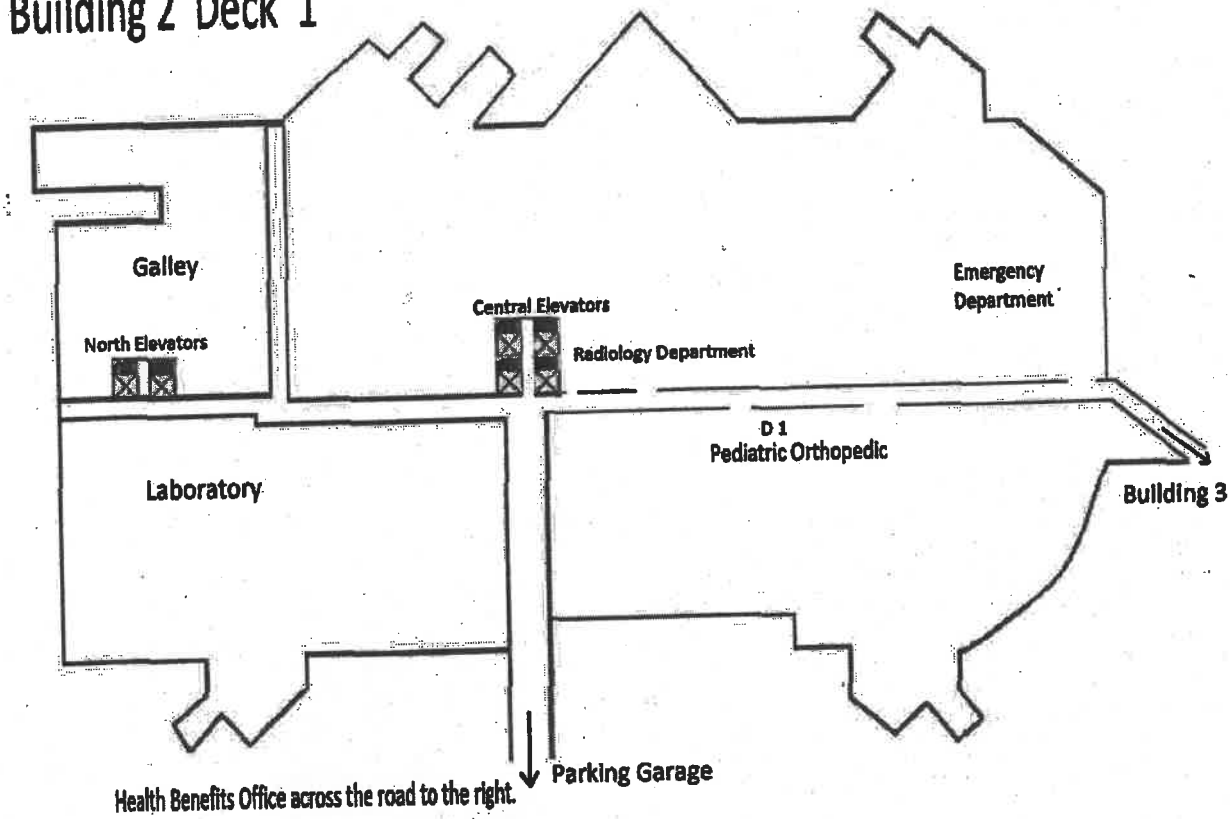
QR Code App
Interactive Customer Evaluation

Building 2 Deck 2



* Development Pediatrics / EFMP
Building 3 deck 2 all the way to the wall, then turn Right (EFMP Office on the Left), and Right again at Development Pediatric Office.

Building 2 Deck 1



Health Benefits Office across the road to the right.

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)	Yes	No