12 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ______________________

Name: ______________________________________ DOB:___________ Male Female

Physician Signature:______________________________________

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your child's health?	**NO**	**YES**
Any problems with previous immunizations?	**NO**	**YES**
Do you have an concerns about managing your child's behavior?	**NO**	**YES**
Feeding/ Nutrition		
Is your child breast feeding still?	**YES**	**NO**
How often?		
Is your child taking formula or milk well?	**YES**	**NO**
How many ounces?		
Which formula or milk?		
Is your child getting three meals of solid foods per day?	**YES**	**NO**
Is your child feeding him or herself?	**YES**	**NO**
Can your child drink from a sippy cup?	**YES**	**NO**
Is your child weaning from the bottle?	**YES**	**NO**
Does your child drink juice or other sweetened drinks?	**NO**	**YES**
Is your child taking any vitamins or supplements?	**YES**	**NO**
Oral Health		
Are cavities a problem for you or anyone in your family?	**NO**	**YES**
Does your child sleep with a bottle?	**NO**	**YES**
Does your child breast or bottle-feed during the night?	**NO**	**YES**
Are you using a soft toothbrush or cloth to clean child's teeth two times a day?	**YES**	**NO**
Does your water contain fluoride or is your child on a fluoride supplement?	**YES**	**NO**
Do you have a dentist for your child?	**YES**	**NO**
Elimination		
Are they having problems with bowel movements (pooping)?	**NO**	**YES**
Activity/Exercise/Screen time		
Does your child watch TV?	**NO**	**YES**
Do you play and read to your child everyday?	**YES**	**NO**
Does your child get supervised floor time every day?	**YES**	**NO**
Sleep		
Does your child sleep through the night?	**YES**	**NO**
Do you have a bedtime routine?	**YES**	**NO**
Social Stressors		
Are you able to take a little time for yourself?	**YES**	**NO**
Any major changes or stresses in your family recently?	**NO**	**YES**
Do you ever worry your family will go hungry?	**NO**	**YES**
Do you have daycare concerns?	**NO**	**YES**

12 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: ______________________________________ DOB:__________

Development		
Does your child babble and imitate words and sounds?	**YES**	**NO**
Does your child say one or two words?	**YES**	**NO**
Does your child point to show wishes or interest?	**YES**	**NO**
Do they follow simple directions?	**YES**	**NO**
Do they hand you a book to read?	**YES**	**NO**
Do they wave bye-bye and play peek-a-boo?	**YES**	**NO**
Does your child bang toys together?	**YES**	**NO**
Do they cry when you leave?	**YES**	**NO**
Are they eating finger foods with thumb and forefinger (pincer)?	**YES**	**NO**
Are they walking with minimal or no assistance?	**YES**	**NO**
Are they creeping up the stairs?	**YES**	**NO**
Lead		
Are you living in a house built prior to 1978?	**NO**	**YES**
Is there any peeling or chipping paint?	**NO**	**YES**
Is there any recent, ongoing, or planning of remodeling?	**NO**	**YES**
Has a sibling or playmate ever had lead poisoning?	**NO**	**YES**
Safety		
Do you always stay close enough to touch your child when he/she is in the bath?	**YES**	**NO**
Does your child wear any jewelry including necklaces?	**NO**	**YES**
Do you hold or carry hot liquids around the baby?	**NO**	**YES**
Do you have a gate on your stairs?	**YES**	**NO**
Is your child's crib mattress at the lowest position?	**YES**	**NO**
Do you have a swimming pool, pond, or lake near your home?	**NO**	**YES**
Do you keep plastic bags and latex balloons away from your baby?	**YES**	**NO**
Does your baby ride in a rear facing safety seat, in the back seat?	**YES**	**NO**
Is your baby exposed to anyone who smokes?	**NO**	**YES**
Have you turned the water heater to below 120 degrees?	**YES**	**NO**
Have you constructed barriers around space heaters, wood stoves, etc.?	**YES**	**NO**
Are there working smoke detectors and carbon monoxide detectors in the home?	**YES**	**NO**
Have you locked up your household cleaners, chemicals, and medicines?	**YES**	**NO**
Do you keep furniture away from windows or use window guards?	**YES**	**NO**
Is there a gun in the home?	**NO**	**YES**
Is it locked or in a safe?	**YES**	**NO**
Do you have the number for Poison Control?	**YES**	**NO**
Are you using sunscreen or shading your baby, if they are in the sun more than 10 minutes?	**YES**	**NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	**NO**	**YES**
Has a family member or contact had a positive TB skin test (PPD)?	**NO**	**YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	**NO**	**YES**
Has your baby traveled to a high-risk country for more than a week?	**NO**	**YES**
Review of Systems		
Do you have any concerns about your baby's hearing?	**NO**	**YES**
Do you have any concerns about your baby's vision?	**NO**	**YES**
Does your baby ever appear cross-eyed?	**NO**	**YES**