Northwest PRIMARY CARE

15 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB: _____ Male Female

Physician Signature: _____

Instructions: Please answer the questions below about your child 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
Feeding/ Nutrition		
Is your child still breast feeding?	○ YES	○ NO
How often?		
Is your child taking formula or milk well?	○ YES	○ NO
How many ounces?		
Which formula or milk?		
Does your child have fruits or vegetables at every meal?	○ YES	○ NO
Are you giving your child mostly whole grains?	○ YES	○ NO
Do you avoid giving your child choking foods (raw vegetables, nuts, hotdogs, popcorn)?	○ YES	○ NO
Does your child still drink from a bottle?	○ NO	○ YES
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		
Does your child have problems with bowel movements (pooping)?	○ NO	○ YES
Activity/Exercise/Screen time		
Does your child watch TV?	○ NO	○ YES
Do you play with your child every day?	○ YES	○ NO
Do you read to your child every day?	○ YES	○ NO
Sleep		
Does your child sleep through the night?	○ YES	○ NO
Do you have a bedtime routine?	○ YES	○ NO
Does your child fall asleep on their own in their own bed?	○ YES	○ NO

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Social Stressors		
Are you able to take some 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
Does your partner ever hurt you or your children?	○ NO	○ YES
Do you have daycare concerns?	○ NO	○ YES
Behavior		
Does your child display excessive tantrums?	○ NO	○ YES
Do you have questions about discipline?	○ NO	○ YES
Do you praise your child when they are behaving well?	○ YES	○ NO
Development		
Does your child know one body part?	○ YES	○ NO
Does your child communicate wishes well?	○ YES	○ NO
Does your child bring objects to show you?	○ YES	○ NO
Does you child jabber a great deal?	○ YES	○ NO
Do they say four to five words clearly?	○ YES	○ NO
Do they understand and follow simple commands?	○ YES	○ NO
Are they walking well?	○ YES	○ NO
Do they enjoy scribbling?	○ YES	○ NO
Do they copy things you do?	○ YES	○ NO
Do they listen to stories?	○ YES	○ NO
Safety		
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 infant ride in a rear facing safety seat, in the back seat?	○ YES	○ NO
Is your infant exposed to anyone who smokes?	○ NO	○ YES
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
Is there a gun in the home?	○ NO	○ YES
If 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