



Dear Parents of Guardians of our Pediatric Patients,

Your child is due for an appointment for either an 18-month or 24-month Well-Child visit. At this visit, we will be screening for Autism spectrum disorders (ASDs).

Autism spectrum disorders (ASDs) are a group of related brain-based disorders that affect a child's behavior, social, and communication skills. They include three pervasive developmental disorders (PDD):

- Autistic Disorder
- Asperger syndrome
- PDD-not otherwise specified

Approximately 1 in 150 children are diagnosed with an ASD. ASDs are lifelong conditions with no known cure. However, children with ASD can progress developmentally and learn new skills. Some children may improve so much that they no longer meet the criteria for ASD, although milder symptoms may often persist. We strongly believe in the importance of early and continuous surveillance and screening for ASD to ensure that children are identified and receive access to services as early as possible. The sooner autism is identified, the sooner an intervention program can start.

About 25% of children will seem to have normal development until about 18 months, after which they will gradually or suddenly stop talking, stop waving goodbye, stop turning their head when their name is called, and withdraw into a shell and seem more distant and less interested in their surroundings.

Attached is a questionnaire called M-CHAT (Modified Checklist for Autism in Toddlers). This is to be completed at age 18 months **and** at 24 months. We would like you to answer the questions to the best of your ability. Please bring the completed form with you to your child's office appointment. We will score this questionnaire and let you know the results.

Thank you for your participation.

David McAnulty, M.D.  
Medical Director  
Northwest Primary Care Group



**M-CHAT**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Filled out by: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Practitioner: \_\_\_\_\_

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.?	YES	NO
2. Does your child take an interest in other children?	YES	NO
3. Does your child like climbing on things, such as up stairs?	YES	NO
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	YES	NO
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	YES	NO
6. Does your child ever use his index finger to point, to ask for something?	YES	NO
7. Does your child ever use his/her index finger to point, to indicate interest in something?	YES	NO
8. Can your child play properly with toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them?	YES	NO
9. Does your child ever bring objects over to you (parent) to show you something?	YES	NO
10. Does your child look you in the eye for more than a second or two?	YES	NO
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	YES	NO
12. Does your child smile in response to your face or your smile?	YES	NO
13. Does your child imitate you? (e.g., you make a face-will your child imitate it?)	YES	NO
14. Does your child respond to his/her name when you call?	YES	NO
15. If you point at a toy across the room, does your child look at it?	YES	NO
16. Does your child walk?	YES	NO
17. Does your child look at things you are looking at?	YES	NO
18. Does your child make unusual finger movements near his/her face?	YES	NO
19. Does your child try to attract your attention to his/her own activity?	YES	NO
20. Have you ever wondered if you child is deaf?	YES	NO
21. Does your child understand what people say?	YES	NO
22. Does you child sometimes stare at nothing or wander with no purpose?	YES	NO
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	YES	NO



## 18 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.

<b>General Health</b>		
Do you have concerns about your child's health?	NO	YES
Any problems with previous immunizations?	NO	YES
<b>Feeding/ Nutrition</b>		
Is your child still breast feeding?	NO	YES
Is your child taking formula or milk well?	YES	NO
How many ounces per day?		
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 family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
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
<b>Oral Health</b>		
Are cavities a problem for you or anyone in your family?	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
<b>Elimination</b>		
Does your child have any problems with bowel movements (pooping)?	NO	YES
Do you have any questions about toilet training?	NO	YES
<b>Activity/Exercise/Screen time</b>		
Does your child watch TV?	NO	YES
Do you play and read to your child every day?	YES	NO
<b>Sleep</b>		
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
<b>Social Stressors</b>		
Are you able to take some time for yourself?	YES	NO
Have you had 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
Does your partner ever hurt you or your children?	NO	YES

# 18 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>Behavior</b>		
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
<b>Development</b>		
Does your child know two body parts?	YES	NO
Does your child have a vocabulary of six words?	YES	NO
Does your child understand and respond to simple requests?	YES	NO
Does your child indicate what they want by pointing or pulling, etc?	YES	NO
Does your child wave bye-bye?	YES	NO
Can your child stack two small blocks?	YES	NO
Can they use a spoon and cup without spilling most of the time?	YES	NO
Do they run well?	YES	NO
Can they climb up and down stairs by holding on?	YES	NO
<b>Lead</b>		
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
<b>Safety</b>		
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 child 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
Do you have a gate on your stairs?	YES	NO
Do you have a fire escape plan?	YES	NO
Do you keep you child away from the stove?	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
Do you keep furniture away from windows or use window guards?	YES	NO
<b>Tuberculosis</b>		
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
<b>Review of Systems</b>		
Do you have any concerns about your baby's hearing?	NO	YES
Do you have any concerns about your baby's vision?	NO	YES