

# Your Child's 18 Month Well-Visit

Child's Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

This form will help us give your child the best care possible. We will use it to focus the visit on the information you would like to receive.

This tool was developed by the Child and Adolescent Health Measurement Initiative (CAHMI). Visit [www.wellvisitplanner.org](http://www.wellvisitplanner.org) or contact [cahmi@ohsu.edu](mailto:cahmi@ohsu.edu) for further information.

Your Name: \_\_\_\_\_ Your relationship to the child: \_\_\_\_\_

Share with me one thing that **your child is able to do** that you are excited about: \_\_\_\_\_

Are there any specific **concerns** you want to discuss today?  No  Yes \_\_\_\_\_

Have there been any **major** changes in your family lately?  None  Move  Job Change  Separation  Divorce

Death in the family  Other? Describe: \_\_\_\_\_

## GENERAL HEALTH INFORMATION

	Yes	No
Since your last visit, has your child had any <b>major</b> illnesses and/or hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a bad reaction to a vaccine (temp>104, inconsolable crying>3 hours)?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your child's relatives developed new medical problems since the last visit?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble paying for supplies like food, clothes and shoes?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child live with both parents in the same home?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have at least one person whom you trust and to whom you can go with personal difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Do any adults who are around your child smoke? (includes inside or outside the house)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dentist for your child?	<input type="checkbox"/>	<input type="checkbox"/>
In general, how well do you feel you are coping with the day-to-day demands of parenthood?		
<input type="checkbox"/> Not well at all <input type="checkbox"/> Not very well <input type="checkbox"/> Somewhat well <input type="checkbox"/> Well <input type="checkbox"/> Very well		

**PICK YOUR PRIORITIES: UP TO FIVE** Tell us what you want to talk about today by checking up to **5** boxes **TOTAL** from the topics below (fewer than 5 is OK, too). Find information on the topics below at [www.wellvisitplanner.org/education](http://www.wellvisitplanner.org/education).

### Your Child & Family

- Importance of family time & eating meals together
- Issues related to feeding your child
- Your child's moods & emotions
- Importance of consistent routines & expectations for your child
- The value of parent-toddler playgroups
- Preparing your child for a new baby
- Sibling rivalry
- Making sure you have adequate emotional support

### Your Developing Child

- Behaviors to expect in the next few months
- How your child might start to cling to you again or more
- Ways to guide & discipline your child
- Television - why the experts say no TV
- Toilet training
- Promoting Your Child's Communication**
- Importance of using simple words, asking simple questions & repeating what your child said
- Ways to read to your child to promote language development
- How your child talks

### Your Child's Safety

- Installing the car seat correctly
- Setting a positive example by always using your seatbelt
- Preventing injuries indoors & outdoors
- Preventing falls from stairs, windows, & other dangerous places
- What to do if your child swallows poison & when to call poison control center
- Fire safety, smoke detectors & escape routes
- Gun safety in your home and places your child visits
- Other**
- \_\_\_\_\_

## YOUR GROWING AND DEVELOPING CHILD

Do you have any specific concerns about your child's learning, development or behavior?  Not at all  A little  A lot  
Describe: \_\_\_\_\_

Do your child's eyes appear unusual or seem to cross, drift or be lazy?  Yes  No

Do you have any concerns about how your child hears?  Yes  No

**Please check each task your child is able to do right now.**

### Gross Motor

- Take steps backwards
- Run
- Walk up steps on at a time (holding your hand, the wall, or a handrail)

### Fine Motor

- Scribble
- Turn a jar upside down to dump out an object (such as a raisin or Cheerio)
- Stack 2 blocks or toys on top of each other to build a tower

### Social/Emotional

- Help around the house (for example, put a toy away or throw away trash)
- Remove his/her clothing

### Cognitive/Communicative

- Speak at least 1 word (other than mama and dada)
- Speak 6 or more words
- Point to at least one body part that you name