PT ID: _____ Patient's Name: _____

PCP: _____ Date of Birth: _____

Today's Date: _____

# 18 Month Old Parent Observations

**Are there any concerns you would like to discuss today?** _____

_____

**Feedings**:

Any concerns about feedings or weight gain? ..... YES NO

Does your child eat well (i.e. has consistent appetite, not took picky)? ..... YES NO

Your child's diet consists of: (check all that apply)

☐ Breastmilk ☐ Whole Milk (# of oz/day:_____) ☐ Juice (# of oz/day:_____)

☐ Fruits ☐ Vegetables ☐ Meats ☐ Grains ☐ Table foods

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) ..... YES NO

Any concerns about sleep? ..... YES NO

**Development**:

Are you reading to your child? ..... YES NO

Does your child watch TV/tablet/phone/have other screen time? ..... YES NO

(If yes, how much screen time per day? _____)

Do you have any concerns about your child's hearing or vision? ..... YES NO

Any concerns about your child's development? ..... YES NO

Does your child: (check all that apply)

☐ use cup/spoon ☐ scribble ☐ follow 1-step commands

☐ run ☐ use 5-15 words ☐ help with dressing

☐ walk up stairs ☐ throw objects in play ☐ bring books to read

☐ stack 2-3 blocks ☐ point to 2 body parts ☐ show interest in other children

**Social/Behavior**:

If parent(s) work, who cares for your child? _____

Are there any family or social issues you would like to discuss? ..... YES NO

Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? ..... YES NO

Is discipline (such as teaching, setting limits) a problem? ..... YES NO

**Safety/Preventative Health**:

Are you brushing your child's teeth with a smear of fluoride toothpaste? ..... YES NO

Has your child seen a dentist? ..... YES NO

Is your home "child-proofed"? ..... YES NO

Is your home/car a smoke-free environment? ..... YES NO

Does your child use a rear-facing car seat 100% of the time? ..... YES NO

*** A child should be rear-facing as long as possible, until they reach the highest weight or height allowed by their seat***

Do you have any questions/concerns about vaccines? ..... YES NO

Any recent illnesses or fevers in the last 24 hours? ..... YES NO

Does your child have any allergies (that you know of)? ..... YES NO

Please list any medications or supplements you child took this week: _____