Risk Assessment 18 Months

Primary water source contains fluoride	Yes	No	Comment
Do you have a dentist for your child	Yes	No	Comment
Uses spoon and cup without spilling most of the time	Yes	No	Comment
Stacks 2 small blocks	Yes	No	Comment
Runs	Yes	No	Comment
Walks up steps	Yes	No	Comment
Speaks 6 words	Yes	No	Comment
Points to 1 body part	Yes	No	Comment
Laughs in response to others	Yes	No	Comment
Helps around the house	Yes	No	Comment
Concerns about how child hears	No	Yes	Concerns
Concerns about how child sees	No	Yes	Concerns
Concerns about how child speaks	No	Yes	Concerns
Any concerns for crossing, drifting, or lazy eyes	No	Yes	Comment

Hip Dysplasia Risk:

Was baby breech in the last month of pregnancy?	No	Yes	Unknown	Comment
Was your child a multiple (twin, triplet, etc?)	No	Yes	Unknown	Comment
Is there a family history of hip dysplasia?	No	Yes	Unknown	Comment
Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?)	No	Yes	Unknown	Comment

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Lead Risk:

Have any members of the family or your Child's playmates had high blood lead level	No	Yes	Unknown	Comment
Does child live/visit house built before 1978 currently being renovated	No	Yes	Unknown	Comment
Does child live/visit a house/apartment building built before 1950	No	Yes	Unknown	Comment

TB Risk:

Born in country outside of the United States	No	Yes	Unknown	Comment
Traveled or had contact with high TB risk populations longer than a week	No	Yes	Unknown	Comment
Family member or contact had tuberculosis or positive TB skin test	No	Yes	Unknown	Comment
Is the child HIV Infected	No	Yes	Unknown	Comment

Anemia Risk:

Diet includes iron-rich foods such as meat, eggs, iron fortified cereal, or beans	Yes	No	Comment

Anticipatory Guidance:

Teaches child that behaviors like hitting are not ok	Yes	No	Comment	
Plays actively for an hour or more per day	Yes	No	Comment	
Parents set limits for child	Yes	No	Comment	
Hours per day child watches TV	None	Less than 2		# of Hours_____
Has a working smoke and carbon monoxide detector on every floor of the home	Yes	No	Comment	
Parent knows the number for poison control	Yes	No	Comment	
Keeps child away from stove	Yes	No	Comment	N/A
Has a gate on stairs	Yes	No	Comment	N/A
Keeps furniture away from windows and uses window guards on 2nd floor windows	Yes	No	Comment	N/A
Have a gun in home, or in any home child sleeps in	No	Yes	Comment	
If so are guns unloaded and locked away	Yes	No	N/A	

Child's name _____ Date _____

Age _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No