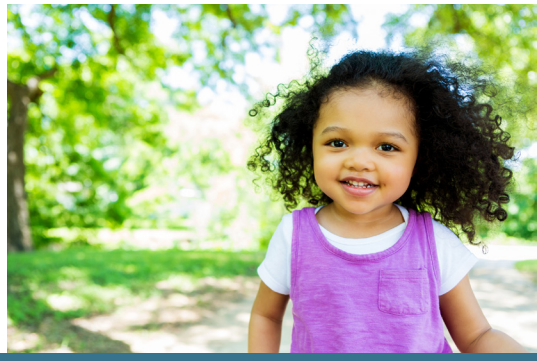
The Smarter Choice for Care

Middlesex Health





15 Month Well-Child Visit
Pre-Appointment Paperwork

Please complete the following forms prior to your child's upcoming well-child visit. All forms are fillable PDFs that can be completed on your computer/smartphone, or you can print this packet and fill it in by hand.

If you are coming to our office, please bring these forms to the appointment.

If you have scheduled a virtual visit, please email the completed forms to your provider's office. Provider emails are available at middlesexhealth.org/wellchild.

We look forward to seeing you soon!

Updated: khc, 9/20/2020

SWYC:™ 15 months

15 months, 0 days to 17 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Calls you "mama" or "dada" or similar name	○	○	○
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	○	○	○
Copies sounds that you make	○	○	○
Walks across a room without help	○	○	○
Follows directions - like "Come here" or "Give me the ball"	○	○	○
Runs	○	○	○
Walks up stairs with help	○	○	○
Kicks a ball	○	○	○
Names at least 5 familiar objects - like ball or milk	○	○	○
Names at least 5 body parts - like nose, hand, or tummy	○	○	○

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	○	○	○
Does your child have a hard time in new places?	○	○	○
Does your child have a hard time with change?	○	○	○
Does your child mind being held by other people?	○	○	○
Does your child cry a lot?	○	○	○
Does your child have a hard time calming down?	○	○	○
Is your child fussy or irritable?	○	○	○
Is it hard to comfort your child?	○	○	○
Is it hard to keep your child on a schedule or routine?	○	○	○
Is it hard to put your child to sleep?	○	○	○
Is it hard to get enough sleep because of your child?	○	○	○
Does your child have trouble staying asleep?	○	○	○

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS			
	Not at All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	◯	◯	◯
Do you have any concerns about your child's behavior?	◯	◯	◯

Your provider will score the previous sections.

In addition to the SWYC, please complete the following section about your child's experiences.

ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE

Stressful events like trouble getting food, violence, or loss are common and can affect your child's health and development. Please read the statements below, HOW MANY statements apply to your child? Write the total number (0-10) in the box.

At any point since your child was born:

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

Adapted with permission from the Center for Youth Wellness ACE Questionnaire (ACE-Q).
2018

Two Question Screen

PHQ-2 (Patient Health Questionnaire) for Parents

PATIENT (CHILD) NAME: **PATIENT DOB:**

PARENT NAME:

Over the **last two weeks,** how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed or hopeless	○	○	○	○