

Please read each question -carefully and

1. Check the box that best describes your child's behavior *and*

2. Check the circle 0 if this behavior is a concern

MOST
OF THE
TIME

SOMETIMES

RARELY
OR
NEVER

CHECK IF
THIS IS A
CONCERN

1. Does your child look at you when you talk to him?

z v x 0

2. When you leave, does your child remain upset and cry for more than an hour?

x v z 0

3. Does your child laugh or smile when you play with her?

z v X 0

4. Does your child look for you when a stranger approaches?

z v x 0

5. Is your child's body relaxed?

z v x 0

6. Does your child like to be hugged or cuddled?

z v x 0

7. When upset, can your child calm down within 15 minutes?

z v x 0

8. Does your child stiffen and arch his back when picked up?

x v z 0

9. Does your child cry, scream, or have tantrums for long periods of time?

x v z 0

Name _____ DOB _____ MR# _____ TOTAL POINTS ON _____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> 0
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 0
12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 0
13. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 0
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> 0
15. Does your child sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> 0
16. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> 0
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 0

TOTAL POINTS ON PAGE ____

CHP Health Center for children ages 15 through 20 months

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child let you know how she is feeling with gestures or words? For example, does she let you know when she is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
19. Does your child follow simple directions? For example, does he sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
20. Does your child like to play near or be with family members and friends?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
21. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
22. Does your child like to hear stories or sing songs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	C
24. Does your child like to be around other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	C
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0

TOTAL POINTS ON PAGE _____



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26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

	MOST OF THE TIME	SOMETIME	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

28. Is there anything that worries you about your child? If so, please explain:

29. What things do you enjoy most about your child?

Person filling out form _____
 Relationship to child _____

TOTAL POINTS ON PAGE ____