

General

1. List any concerns you want to discuss today:

2. Do you read to your child most days? Yes No

3. Does your child have screen time (smartphone, tablet, TV)? No Yes

Nutrition

4. How many cups of milk is your child drinking per day?

5. When your child eats grains (like cereal, bread, pasta, crackers, waffles, rice) are they mostly whole grains? Yes No

6. Is your child eating 5 or more servings of fruits and vegetables daily? Yes No

7. Does your child drink juice or other sweetened drinks? No Yes

8. Does your child still drink from a bottle? No Yes

9. Does your child have any problems with bowel movements (poop)? No Yes

Oral health

10. Is your child seeing a dentist? Yes No

Social stressors

11. Are you having any family stress? No Yes

12. Is there someone in your life that hurts you or your children? No Yes

13. Within the past 12 months have you worried that your food would run out before you got money to buy more? Never Sometimes Often

Lead

14. Is your child regularly in a house built before 1978? No Yes

15. Does your child have a brother, sister or playmate who ever had lead poisoning? No Yes

Developmental milestones

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. Please be sure to answer all the questions.

Adapted from SWYC, 15 months

	Not yet	Somewhat	Very much
16. Calls you "mama" or "dada" or a similar name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Copies sounds that you make	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Walks across a room without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Follows directions, like "Come here" or "Give me the ball"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Runs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Walks up stairs with help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Kicks a ball	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Names at least 5 familiar objects, like "ball" or "milk"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Names at least 5 body parts, like "nose," "hand," or "tummy"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Safety checklist	True	I have questions
26. My child rides in a rear-facing safety seat, in the back seat.	<input type="checkbox"/>	<input type="checkbox"/>
27. We have working smoke/carbon monoxide detectors at home.	<input type="checkbox"/>	<input type="checkbox"/>
28. We apply sunscreen if out in the sun for longer than 15-30 minutes.	<input type="checkbox"/>	<input type="checkbox"/>
29. The crib mattress is at the lowest position.	<input type="checkbox"/>	<input type="checkbox"/>
30. No one smokes or vapes around my child.	<input type="checkbox"/>	<input type="checkbox"/>
31. All our household cleaners, chemicals, knives and medicines are locked up or out of our child's reach.	<input type="checkbox"/>	<input type="checkbox"/>
32. There is a fence with a secure gate preventing our child from accessing the pool/lake/river near or home (or there is no pool, lake or river nearby).	<input type="checkbox"/>	<input type="checkbox"/>
33. Our gun is locked up, with the ammunition separate (or we don't have a gun).	<input type="checkbox"/>	<input type="checkbox"/>
34. We keep plastic bags and latex balloons away from our child.	<input type="checkbox"/>	<input type="checkbox"/>