

|               | TUTAH VALLEY PEDIATRICS |
|---------------|-------------------------|
| Child's Name: |                         |
| Birth Date:   |                         |
| Today's Date: |                         |

15 months, 0 days to 17 months, 31 days V1.08, 9/1/19

| DEVELOPMENTAL MILESTONES | EVELO | PMENTAL | MILEST | ONES |
|--------------------------|-------|---------|--------|------|
|--------------------------|-------|---------|--------|------|

| Most children | at this age will l | oe able to do sor | ne (but not all | ) of the develo | opmental tasks | listed below. | Please tell |
|---------------|--------------------|-------------------|-----------------|-----------------|----------------|---------------|-------------|
| us how much   | your child is doi  | ng each of these  | things. PLEA    | SE BE SURE      | TO ANSWER      | ALL THE QU    | JESTIONS.   |

| N   | ot Yet | Somewhat | Very Much |
|---|--------|----------|-----------|
| Calls you "mama" or "dada" or similar name · · · · · · · ·        | 0      | 1        | 2         |
| Looks around when you say things like "Where's your bottle?" or   | 0      | 1        | 2         |
| Copies sounds that you make · · · · · · · · · · · ·               | 0      | 1        | 2         |
| Walks across a room without help                                  | 0      | 1        | 2         |
| Follows directions - like "Come here" or "Give me the ball" · · · | 0      | 1        | 2         |
| Runs  | 0      | 1        | 2         |
| Walks up stairs with help · · · · · · · · · · · · · · · · · · ·   | 0      | 1        | 2         |
| Kicks a ball  | 0      | 1        | 2         |
| Names at least 5 familiar objects - like ball or milk             | 0      | 1        | 2         |
| Names at least 5 body parts - like nose, hand, or tummy           | 0      | 1)       | 2         |

| 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.

| No  | t at all | Somewhat | Very Much |
|---|----------|----------|-----------|
| Does your child have a hard time being with new people? · · · · · | 0        | 1        | 2         |
| Does your child have a hard time in new places? · · · · ·         | 0        | 1        | 2         |
| Does your child have a hard time with change? · · · · ·           | 0        | 1        | 2         |
| Does your child mind being held by other people? · · · · ·        | 0        | 1        | 2         |
|   |          |          |           |
| Does your child cry a lot? · · · · · · · · · · · ·                | 0        | 1        | 2         |
| Does your child have a hard time calming down? · · · · · ·        | 0        | 1        | 2         |
| Is your child fussy or irritable? · · · · · · · · · · · ·         | 0        | 1        | 2         |
| Is it hard to comfort your child? · · · · · · · · · · · ·         | 0        | 1        | 2         |
|   |          |          |           |
| Is it hard to keep your child on a schedule or routine? · · · · · | 0        | 1        | 2         |
| Is it hard to put your child to sleep? · · · · · · · · · ·        | 0        | 1        | 2         |
| Is it hard to get enough sleep because of your child? · · · · ·   | 0        | 1        | 2         |
| Does your child have trouble staying asleep? · · · · ·            | 0        | 1        | 2         |
|   |          |          |           |