

Patient intake for 18 MONTH HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Is this visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:

Verbal Sign language Written Assistive Communication Device

Preferred method of learning:

Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:

No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.

If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

◆ Do you suspect your toddler is in pain?
Staff- Evaluate pain with FLACC Scale*

YES

NO

Has the patient been seen elsewhere since their last clinic visit with us?

YES

NO

If yes, explain: _____ (◆ Staff- Request Records*)

Review of Symptoms (Place an "X" in all categories that apply):

Poor weight gain		Fever		Cough	
Hearing concerns		Headache		Wheezing	
Vision concerns		Sinus Congestion Present		Vomiting	
Difficulty Breathing		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in bowel habits		Pulling on Ears		Decreased Appetite	
Sweating with feeds		Ear Drainage		Other:	
Rash		Sore Throat			

Family Screening

Are any members of the household currently <u>deployed or on extended duty</u> outside of the immediate area?	YES	NO
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	YES	NO

Nutrition

Feeding Method?

Breast Bottle Spoon/Fork Sippy Cup/Straw Other _____

Feeding Type?

Breastmilk Formula Whole Milk 2% Solids Other: _____

Lead Screen

- What is your child's primary address? _____
- Has a sibling or playmate had lead poisoning? Yes. No. Don't Know.
- Does your child reside in or visit a house or childcare facility built before 1978 which has peeling or chipping paint or has been renovated or remodeled within the last 6 months? Yes. No. Don't Know.
- Does your child come in contact with an adult whose job or hobby involves lead exposure (firing range, metal work, mining, stained glass work, renovation/remodeling)? Yes. No. Don't Know.
- Does your child live in a household eligible for Medicaid, WIC, CHIP, or a state benefits program? Yes. No. Don't Know.
- Is your child a newly arrived refugee, immigrant, or a foreign adoptee? Yes. No. Don't Know.

❖ Corpsmen: check lead exposure risk zone based on address at: <https://fortress.wa.gov/doh/wtnibl/WTNIBL/>
NOTIFY PROVIDER DURING TURNOVER of any "Yes" or "Don't Know" answers for Lead Screen.

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Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	YES	NO

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO
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Family history/Surgeries. Check all that apply.

Family History	Patient surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
◆To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare?	YES	NO

Please turn the page and complete the Developmental Questionnaire. Once you are done, please keep your paperwork with you and wait to be called back.

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! *****



SWYC: 18 months

18 months, 0 days to 22 months, 31 days
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

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.

	Not Yet	Somewhat	Very Much
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
Climbs up a ladder at a playground	0	1	2
Uses words like "me" or "mine"	0	1	2
Jumps off the ground with two feet	0	1	2
Puts 2 or more words together - like "more water" or "go outside"	0	1	2
Uses words to ask for help	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

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...			
Seem nervous or afraid?	0	1	2
Seem sad or unhappy?	0	1	2
Get upset if things are not done in a certain way?	0	1	2
Have a hard time with change?	0	1	2
Have trouble playing with other children?	0	1	2
Break things on purpose?	0	1	2
Fight with other children?	0	1	2
Have trouble paying attention?	0	1	2
Have a hard time calming down?	0	1	2
Have trouble staying with one activity?	0	1	2
Is your child...			
Aggressive?	0	1	2
Fidgety or unable to sit still?	0	1	2
Angry?	0	1	2
Is it hard to...			
Take your child out in public?	0	1	2
Comfort your child?	0	1	2
Know what your child needs?	0	1	2
Keep your child on a schedule or routine?	0	1	2
Get your child to obey you?	0	1	2

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

Does your child bring things to you to show them to you?	Many times a day ☐	A few times a day ☐	A few times a week ☐	Less than once a week ☐	Never ☐
Is your child interested in playing with other children?	Always ☐	Usually ☐	Sometimes ☐	Rarely ☐	Never ☐
When you say a word or wave your hand, will your child try to copy you?	☐	☐	☐	☐	☐
Does your child look at you when you call his or her name?	☐	☐	☐	☐	☐
Does your child look if you point to something across the room?	☐	☐	☐	☐	☐

How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
<i>(please check all that apply)</i>	☐	☐	☐	☐	☐
What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
<i>(please check all that apply)</i>	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

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?	☐	☐	☐

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No						
1 Does anyone who lives with your child smoke tobacco?	☐ (Y)	☐ (N)						
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐ (Y)	☐ (N)						
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐ (Y)	☐ (N)						
4 Has a family member's drinking or drug use ever had a bad effect on your child?	☐ (Y)	☐ (N)						
	Never true	Sometimes true						
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	☐	☐						
Over the past 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				
6 Having little interest or pleasure in doing things?	☐ (0)	☐ (1)	☐ (2)	☐ (3)				
7 Feeling down, depressed, or hopeless?	☐ (0)	☐ (1)	☐ (2)	☐ (3)				
8 In general, how would you describe your relationship with your spouse/partner?	No tension ☐	Some tension ☐	A lot of tension ☐	Not applicable ☐				
9 Do you and your partner work out arguments with:	No difficulty ☐	Some difficulty ☐	Great difficulty ☐	Not applicable ☐				
10 During the past week, how many days did you or other family members read to your child?	☐ (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (5)	☐ (6)	☐ (7)

(Below for Office Staff)

Weight: _____ kg

Respiratory Rate: _____ breaths/min

Length: _____ cm

O2 sat (If indicated): _____

Head Circumference: _____ cm

Temperature: _____

Heart Rate: _____ bpm

(Temporal, oral, tympanic, axillary, rectal)

Lead Exposure Risk Zone: _____

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

18 Month Health Supervision

Your child's growth:

Weight: _____ lb. Percentile: _____
Length: _____ in. Percentile: _____
Head Circumference: _____ cm. Percentile: _____

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process



Eating

- Limit milk to 24 oz per day and try to give mostly with meals.
- Continue to give 3 meals and 2-3 snacks per day.
- Avoid foods that may cause choking (peanuts, hot dogs, popcorn, raw carrots)
- Give your toddler many chances to try a new food.

Click on me to go to the
"HealthyChildren.org" Website!
An American Academy of Pediatrics (AAP)
guide to your child's milestones, growth
and development. Search by age.



Your Changing Toddler

- Follow a regular bed-time routine and schedule. Minimize interaction at night during awakenings.
- Avoid the use of computers, TV, or videos
- Sing, speak and read to your child often.
- Set limits that are important to you and ask others to use them with your toddler.
- Be consistent.
- Keep time-outs brief. Tell your child in simple words what they did wrong.
- Let your child choose between 2 good things for food, drinks, or books.
- Brush teeth twice daily. Only give water after brushing teeth at night.
- Take your child for a first dental visit if you have not done so.

Safety

- Use a rear-facing car safety seat in all vehicles until age 2 years old.
- Never put your child in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Never leave your child alone near water.
- Lock up poisons, medicines, and cleaning supplies. Call Poison Control at 1-800-222-1222 if you need them.

Immunizations

- VAQTA #2 (Hepatitis A)
- Annual Influenza (2 doses for first time influenza vaccination)

When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: <https://centercitypediatrics.com/wait-worry-panic/>

Next health supervision appointment: 24 months of age.

Patient specific guidance:
