

BRIGHT FUTURES HANDOUT ► PARENT

18 MONTH VISIT

Here are some suggestions from Bright Futures experts that may be of value to your family.



✓ YOUR CHILD'S BEHAVIOR

- Expect your child to cling to you in new situations or to be anxious around strangers.
- Play with your child each day by doing things she likes.
- Be consistent in discipline and setting limits for your child.
- Plan ahead for difficult situations and try things that can make them easier. Think about your day and your child's energy and mood.
- Wait until your child is ready for toilet training. Signs of being ready for toilet training include
 - Staying dry for 2 hours
 - Knowing if she is wet or dry
 - Can pull pants down and up
 - Wanting to learn
 - Can tell you if she is going to have a bowel movement
- Read books about toilet training with your child.
- Praise sitting on the potty or toilet.
- If you are expecting a new baby, you can read books about being a big brother or sister.
- Recognize what your child is able to do. Don't ask her to do things she is not ready to do at this age.

✓ TALKING AND HEARING

- Read and sing to your child often.
- Talk about and describe pictures in books.
- Use simple words with your child.
- Suggest words that describe emotions to help your child learn the language of feelings.
- Ask your child simple questions, offer praise for answers, and explain simply.
- Use simple, clear words to tell your child what you want him to do.

✓ HEALTHY EATING

- Offer your child a variety of healthy foods and snacks, especially vegetables, fruits, and lean protein.
- Give one bigger meal and a few smaller snacks or meals each day.
- Let your child decide how much to eat.
- Give your child 16 to 24 oz of milk each day.
- Know that you don't need to give your child juice. If you do, don't give more than 4 oz a day of 100% juice and serve it with meals.
- Give your toddler many chances to try a new food. Allow her to touch and put new food into her mouth so she can learn about them.

✓ YOUR CHILD AND TV

- Do activities with your child such as reading, playing games, and singing.
- Be active together as a family. Make sure your child is active at home, in child care, and with sitters.
- If you choose to introduce media now,
 - Choose high-quality programs and apps.
 - Use them together.
 - Limit viewing to 1 hour or less each day.
- Avoid using TV, tablets, or smartphones to keep your child busy.
- Be aware of how much media you use.

Helpful Resources: Poison Help Line: 800-222-1222

Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

18 MONTH VISIT—PARENT



SAFETY

- Make sure your child's car safety seat is rear facing until he reaches the highest weight or height allowed by the car safety seat's manufacturer. This will probably be after the second birthday.
- Never put your child in the front seat of a vehicle that has a passenger airbag. The back seat is the safest.
- Everyone should wear a seat belt in the car.
- Keep poisons, medicines, and lawn and cleaning supplies in locked cabinets, out of your child's sight and reach.
- Put the Poison Help number into all phones, including cell phones. Call if you are worried your child has swallowed something harmful. Do not make your child vomit.
- When you go out, put a hat on your child, have him wear sun protection clothing, and apply sunscreen with SPF of 15 or higher on his exposed skin. Limit time outside when the sun is strongest (11:00 am–3:00 pm).
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately.

WHAT TO EXPECT AT YOUR CHILD'S 2 YEAR VISIT

We will talk about

- Caring for your child, your family, and yourself
- Handling your child's behavior
- Supporting your talking child
- Starting toilet training
- Keeping your child safe at home, outside, and in the car

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this handout should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original handout included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____

Middle
initial: _____

Child's last name: _____

Child's date of birth: _____

If child was born 3
or more weeks
prematurely, # of
weeks premature: _____

Child's gender:

☐ Male ☐ Female

Person filling out questionnaire

First name: _____

Middle
initial: _____

Last name: _____

Street address: _____

Relationship to child:

☐ Parent ☐ Guardian ☐ Teacher ☐ Child care provider
☐ Grandparent or other relative ☐ Foster parent ☐ Other: _____

City: _____

State/
Province: _____

ZIP/
Postal code: _____

Country: _____

Home
telephone
number: _____

Other
telephone
number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Age at administration in months and days: _____

Program ID #: _____

If premature, adjusted age in months and days: _____

Program name: _____





18 Month Questionnaire

17 months 0 days
through 18 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☒ Try each activity with your baby before marking a response.
- ☒ Make completing this questionnaire a game that is fun for you and your child.
- ☒ Make sure your child is rested and fed.
- ☒ Please return this questionnaire by _____.

Notes:

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your child move around by walking, rather than by crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				GROSS MOTOR TOTAL

**FINE MOTOR**

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your child stack three small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				FINE MOTOR TOTAL



PROBLEM SOLVING

1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)

YES

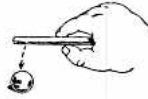
SOMETIMES

NOT YET

☐☐☐

—

2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?

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3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.)

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—

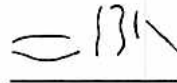
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?

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5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "not yet" if your child scribbles back and forth.)

Count as "yes"



Count as "not yet"

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—

6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.)

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— *

PROBLEM SOLVING TOTAL

—

*If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."

PERSONAL-SOCIAL

1. While looking at herself in the mirror, does your child offer a toy to her own image?

YES

SOMETIMES

NOT YET

☐☐☐

—

2. Does your child play with a doll or stuffed animal by hugging it?

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3. Does your child get your attention or try to show you something by pulling on your hand or clothes?

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4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar?

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—

5. Does your child drink from a cup or glass, putting it down again with little spilling?

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—

6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

☐☐☐

—

PERSONAL-SOCIAL TOTAL

—

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:

☐ YES☐ NO

2. Do you think your child talks like other toddlers his age? If no, explain:

☐ YES☐ NO

3. Can you understand most of what your child says? If no, explain:

☐ YES☐ NO

4. Do you think your child walks, runs, and climbs like other toddlers her age?
If no, explain:

☐ YES☐ NO

5. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

☐ YES☐ NO

6. Do you have concerns about your child's vision? If yes, explain:

☐ YES☐ NO

OVERALL (continued)

7. Has your child had any medical problems in the last several months? If yes, explain:

☐ YES☐ NO

8. Do you have any concerns about your child's behavior? If yes, explain:

☐ YES☐ NO

9. Does anything about your child worry you? If yes, explain:

☐ YES☐ NO



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity
when selecting questionnaire? ☐ Yes ☐ No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	37.38		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	34.32		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	25.74		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	27.19		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

- | | | | | | |
|--------------------------------------------------------------|-----|---------------|------------------------------------------|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Talks like other toddlers his age?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Walks, runs, and climbs like other toddlers?
Comments: | Yes | NO | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
Comments: | | YES No | | | |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ☐ area, it is above the cutoff, and the child's development appears to be on schedule.

If the child's total score is in the ☐ area, it is close to the cutoff. Provide learning activities and monitor.

If the child's total score is in the ☐ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- ☐ Provide activities and rescreen in _____ months.
- ☐ Share results with primary health care provider.
- ☐ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- ☐ Refer to primary health care provider or other community agency (specify reason): _____.
- ☐ Refer to early intervention/early childhood special education.
- ☐ No further action taken at this time
- ☐ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

M-CHAT-R

Child's Name: _____

Date of Birth: _____

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. If you point at something across the room, does your child look at it?
(FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?) | Yes | No |
| 2. Have you ever wondered if your child might be deaf? | Yes | No |
| 3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) | Yes | No |
| 4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs) | Yes | No |
| 5. Does your child make unusual finger movements near his or her eyes?
(FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?) | Yes | No |
| 6. Does your child point with one finger to ask for something or to get help?
(FOR EXAMPLE , pointing to a snack or toy that is out of reach) | Yes | No |
| 7. Does your child point with one finger to show you something interesting?
(FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road) | Yes | No |
| 8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?) | Yes | No |
| 9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck) | Yes | No |
| 10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) | Yes | No |
| 11. When you smile at your child, does he or she smile back at you? | Yes | No |
| 12. Does your child get upset by everyday noises? (FOR EXAMPLE , does your child scream or cry to noise such as a vacuum cleaner or loud music?) | Yes | No |
| 13. Does your child walk? | Yes | No |
| 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? | Yes | No |
| 15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do) | Yes | No |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | Yes | No |
| 17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”?) | Yes | No |
| 18. Does your child understand when you tell him or her to do something?
(FOR EXAMPLE , if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?) | Yes | No |
| 19. If something new happens, does your child look at your face to see how you feel about it?
(FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | Yes | No |
| 20. Does your child like movement activities?
(FOR EXAMPLE , being swung or bounced on your knee) | Yes | No |