SWYC:™ 15 months

15 months, 0 days to 17 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
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	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.

	Not 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

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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	Often 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

	No tension	Some tension	A lot of tension	Not applicable
8 In general, how would you describe your relationship with your spouse/partner?	◯	◯	◯	◯
	No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9 Do you and your partner work out arguments with:	◯	◯	◯	◯

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

11. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household? **Yes No**

12. In the past year, has the utility company shut off your service for not paying your bills? **Yes No**

13. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things you needed for daily living? **Yes No**