

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, score "yes" for the item.

YES SOMETIMES NOT YET




COMMUNICATION *Be sure to try each activity with your child.*

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|-----|
| 1. Without giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?
a. "Put the toy on the table."
b. "Close the door."
c. "Bring me a towel."
d. "Find your coat."
e. "Take my hand."
f. "Get your book." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly <i>name</i> at least one picture? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least <i>seven</i> body parts? (She can point to parts of herself, you, or a doll.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child correctly use at least two words like "me," "I," "mine," and "you"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your child make sentences that are three or four words long?
Please give an example:

_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Without giving him help by pointing or using gestures, ask your child to "Put the shoe <i>on</i> the table" and "Put the book <i>under</i> the chair." Does your child carry out both of these directions correctly? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

COMMUNICATION TOTAL ___

GROSS MOTOR *Be sure to try each activity with your child.*

- | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.) |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. Does your child run fairly well, stopping herself without bumping into things or falling? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child jump with both feet leaving the floor at the same time? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

4. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?



5. Does your child jump forward at least 3 inches with both feet leaving the ground at the same time?



6. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)



 _____*

GROSS MOTOR TOTAL

**If gross motor item 6 is marked "yes" or "sometimes," mark gross motor item 1 as "yes."*

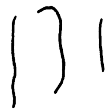
FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

2. Does your child flip light switches off and on?

3. After he watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask your child to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?

Count as "yes"



Count as "not yet"



4. Does your child stack seven small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

5. Does your child thread a shoelace through either a bead or eyelet of a shoe?

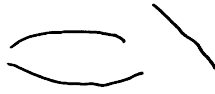


YES SOMETIMES NOT YET

FINE MOTOR *(continued)*

6. After she watches you draw a line from one side of the paper to the other side, ask your child to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?

Count as "yes"



Count as "not yet"



FINE MOTOR TOTAL _____

PROBLEM SOLVING *Be sure to try each activity with your child.*

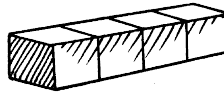
1. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?

2. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?

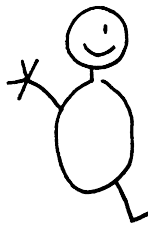
3. When looking in the mirror, ask "Where is _____?" (Use your child's name.) Does your child point to her image in the mirror?

4. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it?

5. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? (You can also use spools of thread, small boxes, or other toys.)



6. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person? Responses like "snowman," "boy," "man," "girl," and "Daddy" are correct.



Please write your child's response here:

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. If you do any of the following gestures, does your child copy at least one of them?

- a. Open and close your mouth.
- b. Blink your eyes.
- c. Pull on your earlobe.
- d. Pat your cheek.

YES SOMETIMES NOT YET

PERSONAL-SOCIAL *(continued)*

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-----|
| 2. Does your child eat with a fork? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your child call herself "I" or "me" more often than her own name? For example, "I do it" more often than "Juanita do it." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Does your child put on a coat, jacket, or shirt by himself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

PERSONAL-SOCIAL TOTAL ___

OVERALL *Parents and providers may use the space below or the back of this sheet for additional comments.*

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you think your child hears well?
If no, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Do you think your child talks like other toddlers her age?
If no, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. Can you understand most of what your child says?
If no, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. Do you think your child walks, runs, and climbs like other toddlers his age?
If no, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. Does either parent have a family history of childhood deafness or hearing impairment?
If yes, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. Do you have concerns about your child's vision?
If yes, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. Has your child had any medical problems in the last several months?
If yes, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. Does anything about your child worry you?
If yes, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |