



SWYC: 24 months

23 months, 0 days to 28 months, 31 days

Child's Name: _____

Birth Date: _____

Today's Date: _____

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
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
Names at least one color	0	1	2
Tries to get you to watch by saying "Look at me"	0	1	2
Says his or her first name when asked	0	1	2
Draws lines	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

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PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

Does your child bring things to you to show them to you?	Many times a day <input type="radio"/>	A few times a day <input type="radio"/>	A few times a week <input type="radio"/>	Less than once a week <input type="radio"/>	Never <input type="radio"/>
Is your child interested in playing with other children?	Always <input type="radio"/>	Usually <input type="radio"/>	Sometimes <input type="radio"/>	Rarely <input type="radio"/>	Never <input type="radio"/>
When you say a word or wave your hand, will your child try to copy you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look at you when you call his or her name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look if you point to something across the room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants <input type="checkbox"/>	Points to it with one finger <input type="checkbox"/>	Reaches for it <input type="checkbox"/>	Pulls me over or puts my hand on it <input type="checkbox"/>	Grunts, cries or screams <input type="checkbox"/>
<i>(please check all that apply)</i>					
What are your child's favorite play activities?	Playing with dolls or stuffed animals <input type="checkbox"/>	Reading books with you <input type="checkbox"/>	Climbing, running and being active <input type="checkbox"/>	Lining up toys or other things <input type="checkbox"/>	Watching things go round and round like fans or wheels <input type="checkbox"/>
<i>(please check all that apply)</i>					

PARENT'S CONCERNS

	Not at all	Somewhat	Very much
Do you have any concerns about your child's learning or development?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have any concerns about your child's behavior?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

FAMILY QUESTIONS

		Yes	No	
1 Does anyone smoke tobacco at home?		<input type="radio"/>	<input type="radio"/>	
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?		<input type="radio"/>	<input type="radio"/>	
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?		<input type="radio"/>	<input type="radio"/>	
4 Has a family member's drinking or drug use ever had a bad effect on your child?		<input type="radio"/>	<input type="radio"/>	
5 In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?		<input type="radio"/>	<input type="radio"/>	
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 Feeling down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 In general, how would you describe your relationship with your spouse/partner?	No tension <input type="radio"/>	Some tension <input type="radio"/>	A lot of tension <input type="radio"/>	Not applicable <input type="radio"/>
9 Do you and your partner work out arguments with:	No difficulty <input type="radio"/>	Some difficulty <input type="radio"/>	Great difficulty <input type="radio"/>	Not applicable <input type="radio"/>