

MONTHLY REPORT

25 to 36 months



Name of Child: _____ Age: _____
 Caseworker: _____ County: _____ For Month, Year _____

The items listed on the right side of the table below represent things a child of THIRTY-SIX MONTHS of age should be doing. Mark the box next to the item in either column if it represents something that is true of your child at this time.

19-24 months	25 – 36 months
Social/Emotional	
<ul style="list-style-type: none"> <input type="checkbox"/> Copies others, especially adults and older children <input type="checkbox"/> Gets excited when with other children <input type="checkbox"/> Shows more and more independence <input type="checkbox"/> Shows defiant behavior (doing what he has been told not to) <input type="checkbox"/> Plays mainly beside other children, but is beginning to include other children, such as in chase games 	<ul style="list-style-type: none"> <input type="checkbox"/> Copies adults and friends <input type="checkbox"/> Shows affection for friends without prompting <input type="checkbox"/> Takes turns in games <input type="checkbox"/> Shows concern for a crying friend <input type="checkbox"/> Understands the idea of “mine” and “his” or “hers” <input type="checkbox"/> Shows a wide range of emotions <input type="checkbox"/> Separates easily from mom and dad <input type="checkbox"/> May get upset with major changes in routine <input type="checkbox"/> Dresses and undresses self
Language/Communication	
<ul style="list-style-type: none"> <input type="checkbox"/> Points to things or pictures when they are named <input type="checkbox"/> Knows names of familiar people and body parts <input type="checkbox"/> Says sentences with 2 to 4 words <input type="checkbox"/> Follows simple instructions <input type="checkbox"/> Repeats words overheard in conversation <input type="checkbox"/> Points to things in a book 	<ul style="list-style-type: none"> <input type="checkbox"/> Follows instructions with 2 or 3 steps <input type="checkbox"/> Can name most familiar things <input type="checkbox"/> Understands words like “in,” “on,” and “under” <input type="checkbox"/> Says first name, age, and sex <input type="checkbox"/> Names a friend <input type="checkbox"/> Says words like “I,” “me,” “we,” and “you” and some plurals (cars, dogs, cats) <input type="checkbox"/> Talks well enough for strangers to understand most of the time <input type="checkbox"/> Carries on a conversation using 2 to 3 sentences
Cognitive (learning, thinking, problem solving):	
<ul style="list-style-type: none"> <input type="checkbox"/> Finds things even when hidden under two or three covers <input type="checkbox"/> Begins to sort shapes and colors <input type="checkbox"/> Completes sentences and rhymes in familiar books <input type="checkbox"/> Plays simple make-believe games <input type="checkbox"/> Builds towers of 4 or more blocks <input type="checkbox"/> Might use one hand more than the other <input type="checkbox"/> Follows two-step instructions such as “Pick up your shoes and put them in the closet.” <input type="checkbox"/> Names items in a picture book such as a cat, bird, or dog 	<ul style="list-style-type: none"> <input type="checkbox"/> Can work toys with buttons, levers, and moving parts <input type="checkbox"/> Plays make-believe with dolls, animals, and people <input type="checkbox"/> Does puzzles with 3 or 4 pieces <input type="checkbox"/> Understands what “two” means <input type="checkbox"/> Copies a circle with pencil or crayon <input type="checkbox"/> Turns book pages one at a time <input type="checkbox"/> Builds towers of more than 6 blocks o Screws and unscrews jar lids or turns door handle
Movement/Physical Development:	
<ul style="list-style-type: none"> <input type="checkbox"/> Stands on tiptoe <input type="checkbox"/> Kicks a ball <input type="checkbox"/> Begins to run <input type="checkbox"/> Climbs onto and down from furniture without help <input type="checkbox"/> Walks up and down stairs holding on <input type="checkbox"/> Throws ball overhand <input type="checkbox"/> Makes or copies straight lines and circles 	<ul style="list-style-type: none"> <input type="checkbox"/> Climbs well <input type="checkbox"/> Runs easily <input type="checkbox"/> Pedals a tricycle (3-wheel bike) <input type="checkbox"/> Walks up and down stairs, one foot on each step

Important Miscellaneous Items: Notify your Doctor, (and placement worker, and county case worker) if, by the end of TWENTY-FOUR MONTHS of age your child:	Important Miscellaneous Items: Notify your Doctor, (and placement worker, and county case worker) if, by the end of THIRTY-SIX MONTHS of age your child:
<input type="checkbox"/> Doesn't use 2-word phrases (for example, "drink milk") <input type="checkbox"/> Doesn't know what to do with common things, like a brush, phone, fork, spoon <input type="checkbox"/> Doesn't copy actions and words <input type="checkbox"/> Doesn't follow simple instructions <input type="checkbox"/> Doesn't walk steadily <input type="checkbox"/> Loses skills she once had	<input type="checkbox"/> Falls down a lot or has trouble with stairs <input type="checkbox"/> Drools or has very unclear speech <input type="checkbox"/> Can't work simple toys (such as peg boards, simple puzzles, turning handle) <input type="checkbox"/> Doesn't speak in sentences <input type="checkbox"/> Doesn't understand simple instructions <input type="checkbox"/> Doesn't play pretend or make-believe <input type="checkbox"/> Doesn't want to play with other children or with toys <input type="checkbox"/> Doesn't make eye contact <input type="checkbox"/> Loses skills he once had

Does the child have regular contacts/visits with family members? Yes No

If YES, fill in the following:

Date & Time ex: 1/1/09; 3-4PM	Location ex: visitation center, foster home, parents' home	Type of contact ex: face to face, phone, email, etc.	With Whom indicate names & relationship, ex: "Susy Smith - mother"

Please note any behavior changes you notice around (before, after, during) visits:

Other Appointments: (visits by caseworkers, GAL's, Bridges staff, medical/therapy, etc.)

Date	Contact	Reason for Visit

Additional Important Dates:

Most recent: Physical exam: _____ Dental exam: _____ Eye exam: _____

Date of most recent doctor's visit _____ Treated for: _____

Next scheduled medical appointment: _____

Report submitted by: _____ Date: _____

Print name: _____