

COOKEVILLE PEDIATRIC ASSOCIATES, P.C.

9 MONTH CHECKUP QUESTIONNAIRE

PATIENT: _____ GUARANTOR: _____
DOB: ___/___/___ DATE: ___/___/___

Source of information: (check one)

Mother _____

Father _____

Other (specify) _____

Which of the following do you have? (check one)

City water _____ Well water _____ Bottled water _____ Spring water _____

Do you breast feed? Yes _____ No _____

How many times per day? _____

Bottle-feeding? Yes _____ No _____

If yes, which formula do you use? _____

WIC services? Yes _____ No _____

Are rice cereal introduced? Yes _____ No _____

Are fruits introduced? Yes _____ No _____

Are vegetables introduced? Yes _____ No _____

Are meats introduced? Yes _____ No _____

Are pureed solid foods introduced? Yes _____ No _____

Are regular table foods introduced? Yes _____ No _____

If so, at what age in months? _____

PROBLEMS: Constipation? Yes _____ No _____

Sleep problems? Yes _____ No _____

Spitting up? Yes _____ No _____

Excessive crying? Yes _____ No _____

Diaper rash? Yes _____ No _____

DEVELOPMENTAL:

Attentive to voices? Yes _____ No _____

Babbles –reciprocally? Yes _____ No _____

Sits without support? Yes _____ No _____

Pulls self to standing position? Yes _____ No _____

Shy with strangers? Yes _____ No _____

Plays peek-a-boo? Yes _____ No _____

Responds to own name? Yes _____ No _____

Crawls/creeps? Yes _____ No _____

Feeds self with fingers? Yes _____ No _____

LEAD: (Mandatory questions)

Does the child live in or regularly visit a house/apartment built before 1950? This could include a daycare center, home of a baby sitter, or a relative?

Yes ___ No ___ Unsure ___

Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?

Yes ___ No ___ Unsure ___

Does the child have a sibling or playmate that has or did have lead poisoning?

Yes ___ No ___ Unsure ___

Does the child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?

Yes ___ No ___ Unsure ___

Does your child frequently come in contact with an adult who works with lead?
(construction, pottery, welding, etc.)

Yes ___ No ___ Unsure ___

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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:



COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. If you ask your baby to, does he play at least one nursery game even if you don't show her the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	COMMUNICATION TOTAL			—






GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				

GROSS MOTOR (continued)




	YES	SOMETIMES	NOT YET	
3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				GROSS MOTOR TOTAL —

FINE MOTOR


	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby successfully pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
				
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				FINE MOTOR TOTAL —

*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

		YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When holding a toy in his hand, does your baby bang it against another toy on the table?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL					—

PERSONAL-SOCIAL

		YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby drink water, juice, or formula from a cup while you hold it?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby feed himself a cracker or a cookie?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PERSONAL-SOCIAL TOTAL					—

OVERALL

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

1. Does your baby use both hands and both legs equally well? If no, explain:

 YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:

 YES NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

 YES NO

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

 YES NO

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

 YES NO

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

 YES NO

OVERALL (continued)

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

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO

Risk Assessment Questionnaire

Patient's Name _____

DOB ____/____/____

Assessment Date ____/____/____

Lead (ages 6 – 72 months): Mandatory questions

	Yes	No	Unsure
Does the child live in or regularly visit a house/apartment built before 1950? This could include a daycare center, home of a baby sitter, or a relative.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have a sibling or a playmate that has, or did have lead poisoning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lead (ages 6 – 72 months): Optional questions

	Yes	No	Unsure
Does child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that your child has low iron?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child live in or regularly visit a house(or daycare facility) built before 1960?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your family use pottery ware or lead crystal for cooking, eating or drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has child been seen eating paint chips, crayons, or soil/dirt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is child given any home or folk remedies that may contain lead (may include moonshine Azarcon, Greta, Payloohah)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your home's plumbing have lead pipes or copper pipes with lead solder joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please note: Lead level laboratory tests are mandatory at 12 and 24 months.

Tuberculosis (Initiate @ one- year)

	Yes	No	Unsure
Has child been in close contact with a person with infectious tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does child have HIV infection or considered at risk for HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does child have a depressed immune system, either because of disease or treatment of disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does child live in an established "high risk for tuberculosis" community or area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cholesterol (Initiate @ two- years)

	Yes	No	Unsure
Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease below age 55?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history (parents and grandparents) of elevated blood cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Bright Futures Parent Handout

9 Month Visit

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

Your Baby and Family

- Tell your baby in a nice way what to do ("Time to eat"), rather than what not to do.
- Be consistent.
- At this age, sometimes you can change what your baby is doing by offering something else like a favorite toy.
- Do things the way you want your baby to do them—you are your baby's role model.
- Make your home and yard safe so that you do not have to say "No!" often.
- Use "No!" only when your baby is going to get hurt or hurt others.
- Take time for yourself and with your partner.
- Keep in touch with friends and family.
- Invite friends over or join a parent group.
- If you feel alone, we can help with resources.
- Use only mature, trustworthy babysitters.
- If you feel unsafe in your home or have been hurt by someone, let us know; we can help.

FAMILY ADAPTATIONS

Feeding Your Baby

- Be patient with your baby as he learns to eat without help.
- Being messy is normal.
- Give 3 meals and 2–3 snacks each day.
- Vary the thickness and lumpiness of your baby's food.
- Start giving more table foods.
- Give only healthful foods.
- Do not give your baby soft drinks, tea, coffee, and flavored drinks.
- Avoid forcing the baby to eat.
- Babies may say no to a food 10–12 times before they will try it.
- Help your baby to use a cup.

FEEDING ROUTINE

FEEDING ROUTINE

- Continue to breastfeed or bottle-feed until 1 year; do not change to cow's milk.
- Avoid feeding foods that are likely to cause allergy—peanut butter, tree nuts, soy and wheat foods, cow's milk, eggs, fish, and shellfish.

Your Changing and Developing Baby

- Keep daily routines for your baby.
- Make the hour before bedtime loving and calm.
- Check on, but do not pick up, the baby if she wakes at night.
- Watch over your baby as she explores inside and outside the home.
- Crying when you leave is normal; stay calm.
- Give the baby balls, toys that roll, blocks, and containers to play with.
- Avoid the use of TV, videos, and computers.
- Show and tell your baby in simple words what you want her to do.
- Avoid scaring or yelling at your baby.
- Help your baby when she needs it.
- Talk, sing, and read daily.

INFANT INDEPENDENCE

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Have your child's car safety seat rear-facing until your baby is at least 1 year old and weighs at least 20 pounds.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your own seat belt and do not drive after using alcohol or drugs.
- Empty buckets, pools, and tubs right after you use them.

SAFETY

- Place gates on stairs; do not use a baby walker.
- Do not leave heavy or hot things on tablecloths that your baby could pull over.
- Put barriers around space heaters, and keep electrical cords out of your baby's reach.
- Never leave your baby alone in or near water, even in a bath seat or ring. Be within arm's reach at all times.
- Keep poisons, medications, and cleaning supplies locked up and out of your baby's sight and reach.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Install openable window guards on second-story and higher windows and keep furniture away from windows.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Keep your baby in a high chair or playpen when in the kitchen.

SAFETY

What to Expect at Your Child's 12 Month Visit

We will talk about

- Setting rules and limits for your child
- Creating a calming bedtime routine
- Feeding your child
- Supervising your child
- Caring for your child's teeth

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



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