Appt Date_____ 9 Month Check Up

Patient Name_____DOB_____
Name of person filling out form _____Phone number_____

Nutrition:

Is your baby breast or bottle fed? (circle all that apply) Formula Breast Milk at the Breast Pumped Breast Milk
If your baby gets formula, which formula are you using?_____
When fed from a bottle, how many ounces will your baby take per feeding? _____
When feeding at the breast, how many minutes will the baby nurse (on both sides combined)? _____
How many total feedings in 24 hours?_____
Have you started giving your baby solids yet?_____
Do you give Vitamin drops? YES NO If so, what kind_____

Bowel/Bladder:

The baby has _____ wet diapers in 24 hours. The baby has _____stools in 24 hours.

Sleep:

Does your baby sleep on his/her back?_____
Where does your baby sleep?_____
How many naps does your baby take during the day?_____ How long are the naps?_____
How many hours does your baby sleep at night?_____

Social hx:

Does your child attend daycare, preschool, or stay at home?_____

Development

Please check the following developmental milestones that you notice your child accomplishing:

___Creeps and crawls on belly
___Pulls up to a stand
___Feeds self finger foods
___Uses pincer grasp
___Looks for hidden objects
___Responds to verbal requests (say bye bye)
___Imitates speech/sounds (nonspecific ma-ma, da-da, ba-ba)
___Sometimes is scared of strangers
___Plays peek-a-boo

Advice and Guidance for Parents: *(please check off as you read)*

___Watch out for: falls, cords and outlets, choking hazards
___Start introducing a sippy cup with water; occasionally put formula in sippy cup so your baby will learn that milk can come in cups. (it takes months to master!)
___Fluoride supplement is needed unless you have city water or drink fluorinated bottled water
___Use sunscreen (SPF 30 or greater) when out for long periods
___Read daily to your child
___Smoke Exposure: Minimize your child's exposure to cigarette smoke
___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____
___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___
___Shift to Stage III solids; begin finger foods, then soft table foods

(for podcasts on Sleep, go to www.shotshurtless.com)

PEDS Response Form

_____
Provider

Child's Name _____ *Parent's Name* _____

Child's Birthday _____ *Child's Age* _____ *Today's Date* _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?
Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?
Circle one: No Yes A little COMMENTS:

Please list any other concerns.

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