Northwest PRIMARY CARE

6 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB:_____ Male Female

Physician Signature: _____

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your baby?	◯ **NO**	◯ **YES**
Is your baby crying longer than 30 minutes at a time?	◯ **NO**	◯ **YES**
Do they have severe nasal stuffiness?	◯ **NO**	◯ **YES**
Do you have concerns about skin color or rash?	◯ **NO**	◯ **YES**
Are they wheezing?	◯ **NO**	◯ **YES**
Did your baby have any problems with previous immunizations?	◯ **NO**	◯ **YES**
Feeding/ Nutrition		
Is your child breast feeding well?	◯ **YES**	◯ **NO**
How often?		
For how long? (minutes)		
Is your child taking formula well?	◯ **YES**	◯ **NO**
How often?		
How many ounces?		
Which formula?		
Are you feeding baby any solid foods?	◯ **YES**	◯ **NO**
Is your baby taking a vitamins or supplements?	◯ **YES**	◯ **NO**
Oral Health		
Are cavities a problem for you or anyone in your family?	◯ **NO**	◯ **YES**
Do you put your baby to bed with a bottle?	◯ **NO**	◯ **YES**
Does your baby wake at night to eat?	◯ **NO**	◯ **YES**
Are you using a soft toothbrush or cloth to clean baby's teeth?	◯ **YES**	◯ **NO**
Does your water contain fluoride or is your child on a fluoride supplement?	◯ **YES**	◯ **NO**
Elimination		
Are they having problems with bowel movements (pooping)?	◯ **NO**	◯ **YES**
Are they urinating (peeing) well?	◯ YES	◯ NO
Sleep		
Are they sleeping six to eight hours at a time?	◯ **YES**	◯ **NO**
Does your baby fall asleep on their own?	◯ **YES**	◯ **NO**
Do you have a bedtime routine?	◯ **YES**	◯ **NO**

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Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	NO	**YES**
Are you able to take a little time for yourself?	**YES**	**NO**
Any major changes or stresses in your family recently?	**NO**	**YES**
Do you ever worry your family will go hungry?	**NO**	**YES**
Do you have daycare concerns?	**NO**	**YES**
Development		
Does your baby babble and imitate sounds?	**YES**	**NO**
Does your baby respond to his/her name?	**YES**	**NO**
Is your baby rolling over both ways?	**YES**	**NO**
Does your baby make eye contact?	**YES**	**NO**
Does your baby reach for things?	**YES**	**NO**
Can your baby sit unassisted for a few seconds?	**YES**	**NO**
Do you read to your baby every day?	**YES**	**NO**
Do you play games like peek-a-boo or play music with your baby?	**YES**	**NO**
Are you starting to work with a sippy cup?	**YES**	**NO**
Safety		
Do you always keep a hand on baby when placed above the floor?	**YES**	**NO**
Does your baby wear any jewelry including necklaces?	**NO**	**YES**
Do you hold or carry hot liquids around the baby?	**NO**	**YES**
Do you keep plastic bags and latex balloons away from your baby?	**YES**	**NO**
Does your baby ride in a rear facing safety seat, in the back seat?	**YES**	**NO**
Is your baby exposed to anyone who smokes?	**NO**	**YES**
Have you turned the water heater to below 120 degrees?	**YES**	**NO**
Have you constructed barriers around space heaters, wood stoves, etc.?	**YES**	**NO**
Are there working smoke detectors and carbon monoxide detectors in the home?	**YES**	**NO**
Have you locked up your household cleaners, chemicals, and medicines?	**YES**	**NO**
Is your baby using a seated infant walker?	**NO**	**YES**
Are you using sunscreen or shading your baby, if they are in the sun more than 10 minutes?	**YES**	**NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	**NO**	**YES**
Has a family member or contact had a positive TB skin test (PPD)?	**NO**	**YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	**NO**	**YES**
Has your baby traveled to a high-risk country for more than a week?	**NO**	**YES**