Northwest PRIMARY CARE

9 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
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?		
Is your baby getting three meals of solid foods per day?	◯ YES	◯ NO
Is you baby trying to feed his or herself?	◯ YES	◯ NO
Can your baby drink from a sippy cup?	◯ YES	◯ NO
Does your baby drink juice or other sweetened drinks?	◯ NO	◯ YES
Is your baby taking any 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 child breast or bottle-feed in the night?	◯ 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
Activity/Exercise/Screen time		
Does your baby watch TV?	◯ NO	◯ YES
Do you read to your baby everyday?	◯ YES	◯ NO
Does your baby get supervised floor time every day?	◯ YES	◯ NO
Sleep		
Are they sleeping six to eight hours at a time?	◯ YES	◯ NO
Does your baby go to sleep by his or herself?	◯ YES	◯ NO
Do you have a bedtime routine?	◯ YES	◯ NO
Social Stressors		
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

9 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name:_____ DOB:_____

Has your partner ever hurt you or your baby?	NO	YES
Development		
Does your baby crow, squeal, babble and imitate speech?	YES	NO
Does your baby make sounds such as “mama” and “dada” (nonspecific)??	YES	NO
Is your baby moving all extremities well?	YES	NO
Do they explore objects by shaking, banging, or throwing them?	YES	NO
Does your baby try to pick up objects with thumb and finger(pincer)?	YES	NO
Can your baby sit well?	YES	NO
Does your baby crawl, creep or scoot on their bottom?	YES	NO
Can they pull themselves to a standing position?	YES	NO
Are they looking for something that has been dropped?	YES	NO
Are they coming to you to play and to be comforted?	YES	NO
Are they playing peek-a-boo?	YES	NO
Are they looking at books?	YES	NO
Lead		
Are you living in a house built prior to 1978?	NO	YES
Is there any peeling or chipping paint?	NO	YES
Is there any recent, ongoing, or planning of remodeling?	NO	YES
Has a sibling or playmate ever had lead poisoning?	NO	YES
Safety		
Do you always stay close enough to touch baby when he/she is in the bath?	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
Do you keep furniture away from windows or use window guards?	YES	NO
Is there a gun in the home?	NO	YES
Is it locked or in a safe?	YES	NO
Do you have the number for Poison Control?	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
Review of Systems		
Do you have any concerns about your baby’s hearing?	NO	YES
Do you have any concerns about your baby’s vision?	NO	YES
Does your baby ever appear cross-eyed?	NO	YES