

Well Child Check: 9 Month Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Does your child sit without support?	Yes	No	Unsure
Can your child get herself up to stand?	Yes	No	Unsure
Does your child take steps holding on to furniture?	Yes	No	Unsure
Does your child pick up objects with the tips of the thumb and fingers?	Yes	No	Unsure
Does your child take finger foods?	Yes	No	Unsure
Does your child babble (talk with made up words/sounds)?	Yes	No	Unsure
Does your child make sounds such as "dada", "mama", or "gaga"?	Yes	No	Unsure
Does your child understand a few words?	Yes	No	Unsure
Does your child look for objects hidden or dropped out of view?	Yes	No	Unsure
Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	Unsure
Does your baby drink breast milk or formula?	Breast milk	Formula	Both
If you are giving formula how many ounces does your child take in 24 hours? _____ oz.			

Type of formula? _____

Do you offer your child a cup or sippy cup every day?	Yes	No	Unsure
Does your child sleep through the night?	Yes	No	Unsure
Is your home child-proofed?	Yes	No	Unsure
Do you usually protect your child with sunscreen/hats/ other measures when outdoors?	Yes	No	Unsure
Do you have any other safety concerns at your home?	No	Yes	Unsure

If so, please describe: _____

Over the past two weeks, has mom ever felt down, depressed or hopeless?	No	Yes	Unsure
Over the past two weeks, has mom felt very little or no interest or pleasure in doing things?	No	Yes	Unsure

Who provides day time care for your child? _____

Does your tap water contain fluoride?	Yes	No	Unsure
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Is your child on any medications or supplements, including fluoride or vitamins? If so, please list below: _____

Do you have any international travel plans prior to your child's first birthday? If so, when and where? _____



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Risk Assessment for Lead Exposure:

Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds? Yes No Unsure

Does your child live in or regularly visit a house or child care facility built before 1978 with peeling or chipping paint inside or outside the home? Yes No Unsure

Does your child have a sibling or playmate who has or did have lead poisoning? Yes No Unsure

Does your family use any of the following IMPORTED items: pottery for cooking or storing food, home remedies, dietary/herbal supplements, candy or eyeliner, (Kohl, Greta, Azarcon, Pay-loo-ah or others)? Yes No Unsure

IF YES, please specify: _____

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider?

If so, please describe:

