Well Child Care 9 months

Name : DOB: Date:

Do you have any concerns today ? □ No Yes_____

Nutrition/Review of systems	yes	no	Review of systems/symptoms	yes	no
Breast feeding ?			Any Vision Problems?		
Bottle feeding ?			Any hearing problems?		
Eating solids ? if yes, eats vegetables ,fruits, meat, fish ? (circle)			Any breathing problems ?		
Spits up ? if yes, is spitting up forceful ?			Any skin problems?		
Drinks milk? _____oz/day			Any heart problems ?		
Drinks juice ? _____oz/day			Any sleep concerns?		
Bowel movements normal ?			Any past bad reactions from immunizations ?		
Has hard stool /cries with bowel movements ?			Any lead poisoning risks?		
Immunizations up to date?			Any TB Exposure?		
Oral Health risk Assessment:					
Mother/ primary caregiver had active tooth decay in past 12 mo			Mother or primary caregiver has a dentist ?		
Frequent snacking ?			Bottle/ sippy cup use with fluids other than water ?		
Special health care needs child?			Medicaid eligible ?		
Child has a dentist ?			Water supply □ city □ well □ drink bottled water		
Has teeth brushed twice daily?			Any dental Concerns?		
Developmental Questions:					
Does your baby jabber?			Does your baby say “dada” or mama?		
Does your baby imitate speech sounds?			Can your baby pick up something small with thumb and finger		
Can your baby bang two cubes together?			Can your baby stand holding on?		
Get into a sitting position by them self ?			Is your baby starting to pull to a standing position?		
Can your baby wave bye- bye?			Can your baby indicate what s/he wants?		
Can your baby play pat a cake?			Do you have any concerns about your baby’s development?		
Safety issues:					
Family violence & substance abuse? circle			Using rear facing car seat?		
Exposed to passive smoking?			Fall, Fire and Burn precaution in place ?		
Home swimming pool ?			Medication, personal hygiene products, alcohol, cleaning supplies ,trash containers out of reach?		
Family history:					
High cholesterol ,Triglycerides			Obesity		
Diabetes			Early Heart disease ,Hypertension		

Anticipatory guidance: *□ discussed and /or handout given*

Family adaptations: *□ limit word "no" □ age-appropriate discipline □ domestic violence*

Infant independence: *□ consistent routines □separation anxiety □learning and developing □No TV*

Feeding routine: *□self-feeding □solid foods □safe foods □using a cup □breastfeeding (Vitamin D, iron supplement) □iron-fortified formula □No bottle in bed □ brush teeth*

Safety: *□ car safety seat □ poisons □ water/drowning □ falls/window guards □burns*

Signature of parent/guardian: **Provider Signature:**