PT ID: _____ Patient's Name: _____

PCP: _____ Date of Birth: _____

Today's Date: _____

9 Month Old Parent Observations

Are there any concerns you would like to discuss today? _____

_____

Feedings:

Any concerns about feedings or weight gain? ..... YES NO

Are you breastfeeding? ..... YES NO If yes, are you giving Vitamin D drops? ..... YES NO

If bottle feeding: ☐ Pumped breastmilk ☐ Formula (Name: _____)

Baby foods: ☐ Cereals ☐ Fruits ☐ Vegetables ☐ Meats ☐ Table foods

Voiding/Stooling:

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) ..... YES NO

Quality of stools: ☐ Liquidy/Seedy ☐ Soft/Formed ☐ Hard pellets/Logs

Sleep:

Any concerns about sleep? ..... YES NO

Is your child sleeping on his/her back? ..... YES NO

How many uninterrupted hours of sleep at night (i.e. in between feeds)? _____

How many naps per day? _____ How long is each nap? _____

Is your child sleeping in a: ☐ Crib ☐ Co-Sleeping in bed with parent

Development:

Are you doing tummy time daily with your child? ..... YES NO

Are you reading to your child? ..... YES NO

Do you have any concerns about your child's hearing or vision? ..... YES NO

Any concerns about your child's development? ..... YES NO

Does your child: (check all that apply)

☐ sit well	☐ seek parents for comfort/play	☐ explore books/environment
☐ crawl/scoot	☐ use pincer grasp	☐ wave bye-bye
☐ pull to stand	☐ bang objects together	☐ jabber/imitate sounds
☐ play peek-a-boo	☐ have stranger anxiety	☐ say mama/dada

Social:

If parent(s) plan to return to work, who will be caring for your child? _____

Are there any family or social issues you would like to discuss? ..... YES NO

Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? ..... YES NO

Safety/Preventative Health:

Do you brush your child's teeth? ☐ YES ☐ NO If yes, using fluoride toothpaste? ☐ YES ☐ NO

Does your child use a rear-facing car seat 100% of the time? ..... YES NO

Is your home/car a smoke-free environment? ..... YES NO

Any recent illnesses or fevers in the last 24 hours? ..... YES NO

Any questions or concerns about immunizations? ..... YES NO

Please list any medications or supplements you child took this week: _____