PT ID: ___________________
PCP: ____________________
Today's Date: ____________

Patient's Name: __________________________
Date of Birth: ____________________________

# 6 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: ☐ Not started ☐ Cereals ☐ Fruits ☐ Vegetables ☐ Meats

**Voiding/Stooling**:
Any concerns about voiding or stooling? (i.e. constipation, diarrhea) ................................ YES NO
Quality of stools: ☐ Liquidy/Seedy ☐ Soft/Mushy ☐ 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: ☐ Bassinet ☐ 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
Does your child ever cross his/her eyes? .....................................................................YES NO
Do you have any concerns about your child's hearing or vision? ........................................YES NO

Does your child: (check all that apply)
- ☐ roll over (belly to back OR back to belly)
- ☐ roll over both ways
- ☐ transfer object from hand to hand
- ☐ rake grasp (extending fingers like rake)
- ☐ sit briefly (for few seconds, leaning forward)
- ☐ babble with consonants
- ☐ turn head to your voice
- ☐ respond to play

**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

**Safety/Preventative Health**:
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: ______________________________