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

Patient's Name: __________________________
Date of Birth: ____________________________

# 4 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

**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)
- ☐ lift his/her head 90° above surface
- ☐ have good head control
- ☐ follow with eyes 180°
- ☐ grab for objects
- ☐ push chest up with arms when lying on belly
- ☐ babble and coo
- ☐ smile/laugh
- ☐ roll over (belly to back OR back to belly)

**Social**:
If parent(s) plan to return to work, who will be caring for your child? ______________________________
Are family members and siblings (if any) doing well with the baby? ...................................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: _____________________________