6 Month Well Check-Up

Person completing form: Mother___ Father____ Grandparent____ Other _____

Parental Concerns:
IF YES, please check the following items that apply:
feedings___; spitting up___; sleep issues___; constipation___; colic___; nasal stuffiness___; others, please note below
_____
_____

Relationships:
Who lives in the home with the child?_____
Number of siblings? _____
Are you coping well with your child? No____Yes____
Are you comfortable with your child? No____Yes____
Over the past 2 weeks, have you felt down, depressed or hopeless? No____Yes____
Are there smokers at home? No____Yes____
If yes, do they smoke outside only? No____Yes____

Smoking:
Are there smokers at home? No____Yes____
If so, who? _____

TB Risk Assessment:
Known exposure to person with TB? No____Yes____
If yes, who? _____

Home Environment:
Type of dwelling: (circle one) Apartment House Trailer Other
Heat source: (circle one) Gas Electric Hot water Other
Water source for dwelling: (circle one) City/Municipal Well
Known Lead exposure in home? No____Yes____
If yes, was it removed? No____Yes____
Home built before 1950? No____Yes____
Home built before 1978 with renovations in last 6 months? No____Yes____

Safety:
Infant car seat rear facing in vehicle? No____Yes____
Does your home have:
Carbon monoxide detectors? No____Yes____
Smoke detectors? No____Yes____
Pool/spa at home? No____Yes____
Pets or animals at home? No____Yes____
If yes, what types? _____
Firearms in the home? No____Yes____
If yes, are they in locked storage? No____Yes____

Sleep Habits:
Any concerns? No____Yes____
If yes, explain_____
Does your child take naps? No____Yes____
Does your child sleep in bed with parents? No____Yes____
Does your child sleep through the night? No____Yes____
Does your child sleep on their back? No____Yes____

Nutrition:
Any concerns? _____
Is your child on the WIC program? No____Yes____
Does your child get breast milk? No____Yes____
How often are they feeding? _____
Does your child get formula? No____Yes____
What type? _____
How many ounces per feeding? _____
How often? _____
Do you give your child any juice? No____Yes____
If yes, how many ounces per day? _____
Have you started any baby food? No____Yes____
If yes, how many times per day? _____

Elimination:
Any concerns about urine output? No____Yes____
Any concerns about bowel movements? No____Yes____

Illness/Injuries/Hospitalizations/Surgeries:
Since the last well visit, has your child:
been admitted to the hospital? No____Yes____
Had any surgery? No____Yes____
If yes, please explain _____
_____

Family History:
Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe _____
_____
_____

******See back of form******

Developmental Milestones

	Not At all	Somewhat	Very Much
Makes sounds that like “ga,” “ma,” or “ba”……	○	○	○
Looks when you call his or her name……..	○	○	○
Rolls over ……..	○	○	○
Passes a toy from one hand to the other…..…	○	○	○
Looks for you or another caregiver when upset……..	○	○	○
Hold two objects and bangs them together……..	○	○	○
Holds up arms to be picked up……..	○	○	○
Gets into sitting position by him or herself……..	○	○	○
Picks up food and eats it……	○	○	○
Pulls up to standing……..	○	○	○