9 Month Well Check-Up

Person completing form: Mother___ Father____ Grandparent____ Other _____

Parental Concerns:
Do you have any concerns about your child's learning development?
Not At All ○ Somewhat ○ Very Much ○

Do you have any concerns about your child's behavior?
Not At All ○ Somewhat ○ Very Much ○

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____

Smoking:
Are there any smokers in the house? No____Yes___
If yes, do they smoke outside only? _____

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 dwelling 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____

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? _____
How many times per day do you give baby foods?_____
Have you started any table foods? No____Yes____

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:
Had any injuries or 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 _____
_____

Early Autism:
Does your child:
Point to objects? No____Yes____
Respond to his/her name? No____Yes____
Make eye contact with you? No____Yes____

*****See Back of Form*****

Developmental Milestones

	Not At All	Somewhat	Very Much
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 ……..	○	○	○
Plays games like “Peek-a-Boo,” or “Pat-A-Cake”……..	○	○	○
Calls you “mama,” or “dada”…….	○	○	○
Looks around when you say things like ”Where’s your bottle?” or “Where’s your blanket?”……..	○	○	○
Copies sounds that you make……..	○	○	○
Walks across a room without help……	○	○	○
Follows directions- like “Come here” or “Give me the ball”…..	○	○	○