

9 Month Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child's health that you would like to discuss today?

What is your child's health Status? **Good Fair Poor**

Has your child been to the emergency room in the past 12 months: **Yes No**

If yes, list why: _____

Has your child been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: _____

Has your child ever had any reactions to vaccines / immunizations: **Yes No**

Has your child seen a dentist in the last 6 months: **Yes No**

How many times a day does your child brush their teeth? ____ How many times a day do they floss? ____

HOME and FAMILY

Who does the child live with: _____ How many brothers and sisters does he/she have? _____

What do you live in? _____ How many bedrooms are in your home? _____

Does your child share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your child's Father Involved in his/her care? **Yes No**

How is your child's relationship with his brothers and/or sisters? **Good Fair Poor N/A, only child**

What type of discipline is used in the home: **Verbal Time-out Spanking Other:** _____

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _____

9 Month Well Child Exam Form

GENERAL HEALTH

What type of milk does he/she drink? **Breast milk** **Whole** **2%** **1%** **Fat free** **Lactose free** **Soy**

How much milk/formula does he/she drink in a day? **< 8oz** **8-16 oz** **16-24 oz** **24-32oz** **> 32oz**

How often does he/she feed? Every: **2 hours** **3 hours** **4 hours** **5 hours** **6 hours**

Does your child drink from: **cup** **bottle only** **cup and bottle**

What else does he/she drink and how many glasses a day does he/she drink? **___ Glasses of juice**

___ Glasses of water **___ glasses of caffeinated soda or tea** **___ glasses of decaffeinated soda or tea**

Does your child eat: **no solids** **cereal** **vegetables** **fruits** **meats** **junk food**

Does your child have any problems with bowel movements, including constipation or diarrhea? **Yes** **No**

Does he/she have any problems sleeping? **Yes** **No** If yes, what kind of problems? _____

How would you describe your child's temperament? **Easy** **Colicky** **Demanding**

Cries when hungry or with needs **Fussy all the time** **Fussy at night** **Fussy but consolable**

Do you have any concerns about:

Your child's development? **Yes** **No**

Your child's behavior? **Yes** **No**

HEARING

Does your child:

Turn and look at you when you are speaking in a quiet voice **Yes** **No**

Wave when you say bye-bye **Yes** **No**

Stop for a moment when you say "no" **Yes** **No**

Look at objects or pictures when someone talks about them **Yes** **No**

Babbles song-like tunes **Yes** **No**

Uses his/her voice to get your attention instead of crying **Yes** **No**

Uses different sounds and appears to be naming things **Yes** **No**

VISION

Do you have any concerns about how your child sees **Yes** **No**

Do you child's eyes appear unusual or seem to cross, drift, or be lazy? **Yes** **No**

9 Month Well Child Exam Form

Do your child's eyelids droop or does one eyelid tend to close? **Yes No**

Have your child's eyes ever been injured? **Yes No**

Check off each task that your child is able to do:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pulls to stand | <input type="checkbox"/> Uses pincer grasp | <input type="checkbox"/> Babbles |
| <input type="checkbox"/> Stands holding on | <input type="checkbox"/> Bangs two cubes | <input type="checkbox"/> Says dada/mam |
| <input type="checkbox"/> Gets to sitting | <input type="checkbox"/> Feeds self | <input type="checkbox"/> Waves bye-bye |
| <input type="checkbox"/> Creeps | <input type="checkbox"/> Drinks from a cup | <input type="checkbox"/> Plays peekaboo |
| <input type="checkbox"/> Crawls | <input type="checkbox"/> Responds to name | <input type="checkbox"/> Stranger anxiety |

GENERAL SAFETY

Does your child always use a car seat? **Yes No**

Is your home childproofed? **Yes No**

Do you have these things in your home:

Smoke detector **Yes No**

Carbon monoxide detector **Yes No**

Fire extinguisher **Yes No**

9 Month Well Child Exam Form



9 Month Questionnaire

9 months 0 days
 through 9 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.



Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

COMMUNICATION TOTAL _____

GROSS MOTOR



	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

9 Month Well Child Exam Form








9 Month Questionnaire page 3 of 6

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
GROSS MOTOR TOTAL				___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your baby successfully pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___*
				
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
FINE MOTOR TOTAL				___

*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

E101090301




Agar & Stages Questionnaires®, Third Edition (ASQ-3™), Squires & Bricker
 © 2009 Paul H. Brookes Publishing Co. All rights reserved.

9 Month Well Child Exam Form




9 Month Questionnaire page 4 of 6

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When holding a toy in his hand, does your baby bang it against another toy on the table? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
PROBLEM SOLVING TOTAL				___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby drink water, juice, or formula from a cup while you hold it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby feed himself a cracker or a cookie?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
PERSONAL-SOCIAL TOTAL				___

E101090401

Ages & Stages Questionnaires®, Third Edition (ASQ-3™), Squires & Bricker
 © 2009 Paul H. Brookes Publishing Co. All rights reserved.

REVISION DATE: 5/17/2016
 Next Review Date: 5/17/2019

9 Month Well Child Exam Form



9 Month Questionnaire page 5 of 6

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. When you help your baby stand, are his feet flat on the surface most of the time?
If no, explain:

YES

NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

YES

NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

5. Do you have concerns about your baby's vision? If yes, explain:

YES

NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

E101090501

Ages & Stages Questionnaires®, Third Edition (ASQ-3™), Squires & Bricker
© 2009 Paul H. Brookes Publishing Co. All rights reserved.

9 Month Well Child Exam Form



9 Month Questionnaire page 6 of 6

OVERALL (continued)

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO