



Bright Futures Parent Handout 9 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

Your Baby and Family

- Tell your baby in a nice way what to do ("Time to eat"), rather than what not to do.
- Be consistent.
- At this age, sometimes you can change what your baby is doing by offering something else like a favorite toy.
- Do things the way you want your baby to do them—you are your baby's role model.
- Make your home and yard safe so that you do not have to say "No!" often.
- Use "No!" only when your baby is going to get hurt or hurt others.
- Take time for yourself and with your partner.
- Keep in touch with friends and family.
- Invite friends over or join a parent group.
- If you feel alone, we can help with resources.
- Use only mature, trustworthy babysitters.
- If you feel unsafe in your home or have been hurt by someone, let us know; we can help.

FAMILY ADAPTATIONS

Feeding Your Baby

- Be patient with your baby as he learns to eat without help.
- Being messy is normal.
- Give 3 meals and 2–3 snacks each day.
- Vary the thickness and lumpiness of your baby's food.
- Start giving more table foods.
- Give only healthful foods.
- Do not give your baby soft drinks, tea, coffee, and flavored drinks.
- Avoid forcing the baby to eat.
- Babies may say no to a food 10–12 times before they will try it.
- Help your baby to use a cup.

FEEDING ROUTINE

FEEDING ROUTINE

- Continue to breastfeed or bottle-feed until 1 year; do not change to cow's milk.
- Avoid feeding foods that are likely to cause allergy—peanut butter, tree nuts, soy and wheat foods, cow's milk, eggs, fish, and shellfish.

Your Changing and Developing Baby

- Keep daily routines for your baby.
- Make the hour before bedtime loving and calm.
- Check on, but do not pick up, the baby if she wakes at night.
- Watch over your baby as she explores inside and outside the home.
- Crying when you leave is normal; stay calm.
- Give the baby balls, toys that roll, blocks, and containers to play with.
- Avoid the use of TV, videos, and computers.
- Show and tell your baby in simple words what you want her to do.
- Avoid scaring or yelling at your baby.
- Help your baby when she needs it.
- Talk, sing, and read daily.

INFANT INDEPENDENCE

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Have your child's car safety seat rear-facing until your baby is at least 1 year old and weighs at least 20 pounds.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your own seat belt and do not drive after using alcohol or drugs.
- Empty buckets, pools, and tubs right after you use them.

SAFETY

- Place gates on stairs; do not use a baby walker.
- Do not leave heavy or hot things on tablecloths that your baby could pull over.
- Put barriers around space heaters, and keep electrical cords out of your baby's reach.
- Never leave your baby alone in or near water, even in a bath seat or ring. Be within arm's reach at all times.
- Keep poisons, medications, and cleaning supplies locked up and out of your baby's sight and reach.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Install openable window guards on second-story and higher windows and keep furniture away from windows.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Keep your baby in a high chair or playpen when in the kitchen.

SAFETY

What to Expect at Your Child's 12 Month Visit

We will talk about

- Setting rules and limits for your child
- Creating a calming bedtime routine
- Feeding your child
- Supervising your child
- Caring for your child's teeth

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



American Academy
of Pediatrics



The recommendations in this publication do not constitute an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account the child's individual circumstances, may be appropriate. Original document included as part of Bright Futures Tool and Resource Kit, Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any product or service made to this document and in no event shall the AAP be liable for any such charges.

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name: _____

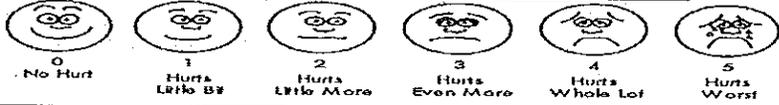
FMP and Sponsor Last Four: _____ / _____

Date: _____

(Patient Label)

If this is the **FIRST** time you are filling in this form, please complete **ALL** areas.
If you have **ALREADY** completed it, please complete **SHADED** areas **ONLY**.

1. **No Allergies** Please list any allergies you have (drug, food, latex) _____

| Clinic Use Only | | | |
|-----------------|---|------|---------------------------------------------------------------------------------------|
| BP | / | HT | Visual Acuity: R 20/____ L 20/____ Both 20/____ |
| HR | | WT | Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____ |
| RR | | HC |  |
| TEMP | | SpO2 | |

(Please complete information below: If filled out before, list only changes since the last visit.)

| Chronic Medical Conditions (Circle all that apply) | Surgeries/Hospitalizations (Dates) (Circle all that apply) | Family History—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM) | Medicines (PLEASE INCLUDE DOSAGE) |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NO Medical Conditions Asthma Diabetes Hayfever/Allergies Other: | NO History of Surgeries Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other: | Birth Defects Deafness before Age 5 Kidney Disease Post Partum Depression Early or Sudden Death to include SIDS Heart attack before age 50 High Blood Pressure High Cholesterol Hypertrophic Cardiomyopathy Long QT syndrome Arrhythmias Diabetes Mental Illness Alcohol or Substance Abuse Genetic or Metabolic Disease Other: | Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter <input type="checkbox"/> Infant Multivitamin 1 ml per day |

BIRTH HISTORY-Complete for AGES NEWBORN TO 2 YEARS

Place of Birth: _____
 Birth weight? _____ # weeks pregnant at delivery? _____
 Prenatal complications No Yes describe: _____
 Group B Strep. (GBS) Positive Negative Don't Know
 Type of Delivery (check all that apply):
 Vaginal Forceps Vacuum-assisted C-section Breech
 Complications at birth?
 Jaundice * Yes No Phototherapy * Yes No Hip Click/Clunk * Yes No
 Other: _____
 Did your child receive the Hepatitis B vaccine at birth? Yes No Unsure

Newborn Metabolic Screen Submitted:

Yes No Don't Know
 Repeated
Baby's Hearing Screen:
 Passed Bilateral
 Repeat Needed
 Don't Know

Clinic Use Only - For Newborns-2 weeks
 Complete Risk assessment for Jaundice (Bill and Blood Type)

Source of Medical Information: Mother Father Patient Other _____
 Any Hospitalizations, specialty care, or ER visits since your last appointment? No Yes:
 Would you say your child's Overall Feeling of health is? Excellent Very Good Good Fair Poor
 Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid? Yes No Decline
 Are your child's immunizations up to date? Yes Unsure No

Does your child have a chronic medical or behavioral health problem, and/or physical disability? No Yes
 Is frequent follow-up support required for the above issues? No Yes
 Does your child require early interventions or special education services? No Yes
 Is your child enrolled in the Exceptional Family Member Program? No Yes

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

Is your child In Day Care

Does anyone in the family smoke or is your child exposed to secondhand smoke? No Yes

Who does the Child Live With? Parents Mother Father Other:

Is Sponsor currently deployed: No Yes

Is this visit deployment related: No Yes

Does your child ride in a car with a car seat? Yes No

Tuberculosis Screening - Complete at 1, 6, 12, and 18 month Well Child Visit

Yes No Unsure Has a family member or contact had tuberculosis?

Yes No Unsure Has a family member had a positive tuberculin skin test?

Yes No Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, or Western Europe)?

Yes No Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

Lead Screening - Complete at 6, 9, 12, and 18 Month Well Child Visit

Yes No Unsure Does your child have a sibling or playmate with Hx of lead poisoning?

Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1950?

Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

What is your preferred method for learning: Verbal Written Visual Hands-On Other: _____

Yes No - Do you or your child have learning/readiness needs?

Yes No - Are there cultural or religious considerations that affect your child's healthcare?

Yes No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?

****PLEASE PROVIDE A GOOD CONTACT NUMBER: _____**

Breastfeeding? Yes No How often? _____ Minutes per breast? _____ Concerns? _____

Bottle feeding? Yes No Brand? _____ Ounces per feed? _____ How often? _____

Number of wet diapers per day? _____ Stools per day? _____

Circle if you have any concerns about the following (circle all that apply): Bowel movements / Constipation / Sleep problems

If Edinburgh Postpartum Depression Screen (EPDS) not attached.
 Mother please complete below questionnaire at 1 week, 2 and 4 month Well Child visits.

Over the last 2 weeks, how often have you been bothered by any of the following?

Little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day

Feeling depressed or hopeless? Not at all Several days More than half the days Nearly every day

----- (This section NOT for patient use) -----

Treatments orders for this visit - Ensure Patients Name and last four on Front of Document:

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------|---------------------------------------|------------------------------------------|------------------------------|
| <input type="checkbox"/> Flu Swab | <input type="checkbox"/> Ear Irrigation | <input type="checkbox"/> CBC | <input type="checkbox"/> Chol Panel | <input type="checkbox"/> Bilirubin (T/D) | <input type="checkbox"/> CXR |
| <input type="checkbox"/> RSV Swab | Left _____ Right _____ | <input type="checkbox"/> UA | <input type="checkbox"/> HbA1c | <input type="checkbox"/> TsBill | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Strep Screen/TCx | <input type="checkbox"/> Saline Bulb Suction | <input type="checkbox"/> CRP/ESR | <input type="checkbox"/> TSH, T4 | <input type="checkbox"/> Monospot | |
| <input type="checkbox"/> Tussin Swab | <input type="checkbox"/> Motrin (PO) _____ mg | <input type="checkbox"/> BMP | <input type="checkbox"/> Iron Profile | <input type="checkbox"/> EBV Titers | |
| <input type="checkbox"/> Dex | <input type="checkbox"/> Tylenol (PO) _____ mg | <input type="checkbox"/> CMP | <input type="checkbox"/> Lead | | |
| <input type="checkbox"/> EVALUATE FOR VACCINE UPDATE <input type="checkbox"/> PPD <input type="checkbox"/> Other _____ | | | | | |
| <input type="checkbox"/> Immunizations - 2 Month = Pediarix (DTaP-IPV-HepB), HIB, PCV-13, Rotateq | | | | | |

Well Child Developmental Screenings

| 1 Week (3-5 days) | | | 1 MONTH | | | 2 MONTH | | |
|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------|
| COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | | COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | | COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | |
| If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit: | | | | | | | | |
| <input type="checkbox"/> Eats well | <input type="checkbox"/> If upset, able to calm | <input type="checkbox"/> Lifts head and begins to push up when prone | <input type="checkbox"/> Follows your face | <input type="checkbox"/> Has started to smile | <input type="checkbox"/> Holds head erect for short period (when held upright) | <input type="checkbox"/> Turns and calms to your voice | <input type="checkbox"/> Recognizes voice of parents | <input type="checkbox"/> Diminished newborn reflexes |
| <input type="checkbox"/> Can suck, swallow and breath easy | <input type="checkbox"/> Follows parents with eyes | <input type="checkbox"/> Indicates boredom when no activity change | <input type="checkbox"/> Able to lift head when on tummy | <input type="checkbox"/> Coos | <input type="checkbox"/> Different crying for different needs | | <input type="checkbox"/> Smiles | <input type="checkbox"/> Looks for parents |
| | | <input type="checkbox"/> Self-comfort | | | | | | |
| 4 MONTH | | | 6 MONTH | | | 9 MONTH | | |
| COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | | COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | | ***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)*** | | |
| If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit: | | | | | | | | |
| <input type="checkbox"/> Pushes chest to elbows | <input type="checkbox"/> Sits briefly, leaning forward | <input type="checkbox"/> Sits well | <input type="checkbox"/> Good Head control | <input type="checkbox"/> Rolls over | <input type="checkbox"/> Crawls | <input type="checkbox"/> Symmetry in movements | <input type="checkbox"/> Uses visual exploration | <input type="checkbox"/> Pulls to feet with support |
| <input type="checkbox"/> Begins to roll and reach for objects | <input type="checkbox"/> Beginning to use oral exploration | <input type="checkbox"/> Peekaboo | <input type="checkbox"/> Responds to affection | <input type="checkbox"/> Uses a string of vowels (ah, eh, oh) | <input type="checkbox"/> Objects permanence | <input type="checkbox"/> Indicates pleasure or displeasure | <input type="checkbox"/> Beginning to recognize own name | <input type="checkbox"/> Looks at book |
| <input type="checkbox"/> Spontaneous expressive babbling | <input type="checkbox"/> Enjoys vocal turn-taking | <input type="checkbox"/> Imitates sounds | <input type="checkbox"/> Social smile | <input type="checkbox"/> Shows pleasure from interaction with parents or others | <input type="checkbox"/> Points out objects | <input type="checkbox"/> Elicits social interactions | | <input type="checkbox"/> Stranger anxiety |
| <input type="checkbox"/> Smiles spontaneously | | <input type="checkbox"/> Seeks parent for comfort | <input type="checkbox"/> Can calm down on own | | | | | |
| 12 MONTH | | | 15 MONTH | | | 18 MONTH | | |
| COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | | COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ) | | | ***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)*** | | |
| If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit: | | | | | | | | |
| <input type="checkbox"/> Waves bye-bye | <input type="checkbox"/> Tries to do what you do | <input type="checkbox"/> Helps in the house | <input type="checkbox"/> Tries to do what you do | <input type="checkbox"/> Helps in the house | <input type="checkbox"/> Laughs in response to others | <input type="checkbox"/> Cries when you leave | <input type="checkbox"/> Listens to a story | <input type="checkbox"/> Speaks 6 words |
| <input type="checkbox"/> Plays Peekaboo | <input type="checkbox"/> Says 2 to 3 words | <input type="checkbox"/> Knows names of favorite books | <input type="checkbox"/> Hands you a book to read | <input type="checkbox"/> Scribbles | <input type="checkbox"/> Points to 1 body part | <input type="checkbox"/> Speaks 1-2 words | <input type="checkbox"/> Follows simple commands | <input type="checkbox"/> Stacks 2 small blocks |
| <input type="checkbox"/> Babbles | <input type="checkbox"/> Bends down without falling | <input type="checkbox"/> Runs | <input type="checkbox"/> Tries to make the same sounds you do | <input type="checkbox"/> Walks well | <input type="checkbox"/> Walk up steps | <input type="checkbox"/> Looks at things you are looking at | <input type="checkbox"/> Puts blocks in a cup | <input type="checkbox"/> Uses spoon and cup without spilling most of the time |
| <input type="checkbox"/> Follows simple directions | <input type="checkbox"/> Puts block in a cup | | <input type="checkbox"/> Bangs toys together | <input type="checkbox"/> Drinks from cup with very little spilling | | | | |

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

AHLTA was not accessible during this patient visit. Reviewed note & agree _____ *(Provider Initial)*

VISIT FOR: Acute Well Child Visit 3-5 day/1 week 1 Month 2 Months 4 Months
 6 Months 9 Months 12 Months 15 Months 18 Months

HPI:

ROS: Check only symptoms that may apply to today's visit.

| | | |
|------------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Cough | <input type="checkbox"/> Poor Weight Gain |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Hearing Concerns |
| <input type="checkbox"/> Nasal Discharge | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Pulling at the Ear(s) | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Eyes Discharge | <input type="checkbox"/> Decrease in Appetite | <input type="checkbox"/> Change in Bowel Habits |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Rash | <input type="checkbox"/> Excessive Thirst |

| NE | Examination: | Normal | Abnormal |
|--------------------------|-----------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> | General: | <input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic | <input type="checkbox"/> |
| <input type="checkbox"/> | Head/Neck: | <input type="checkbox"/> NCAT/AFOF/neck supple | <input type="checkbox"/> |
| <input type="checkbox"/> | Eyes: | <input type="checkbox"/> EOMI, RR X2, NI corneal reflex <input type="checkbox"/> no strabismus | <input type="checkbox"/> |
| <input type="checkbox"/> | R ear: | <input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks | <input type="checkbox"/> Bulging/immobile/red |
| <input type="checkbox"/> | L ear: | <input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks | <input type="checkbox"/> Bulging/immobile/red |
| <input type="checkbox"/> | Nose: | <input type="checkbox"/> Patent, No congestion/discharge | <input type="checkbox"/> Congested |
| <input type="checkbox"/> | Oropharynx: | <input type="checkbox"/> Pink, moist, no cleft or pit | <input type="checkbox"/> |
| <input type="checkbox"/> | Lungs: | <input type="checkbox"/> CTAB, no retractions, NI WOB | <input type="checkbox"/> |
| <input type="checkbox"/> | CV: | <input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec | <input type="checkbox"/> |
| <input type="checkbox"/> | Abd: | <input type="checkbox"/> Soft, NT, no HSM, no masses, ni BS, no umbilical/inguinal hernia | <input type="checkbox"/> |
| <input type="checkbox"/> | Ext/Spine: | <input type="checkbox"/> NL, FROM, nontender, no edema, <input type="checkbox"/> no sacral dimple | <input type="checkbox"/> Sacral Dimple |
| <input type="checkbox"/> | Skin: | <input type="checkbox"/> No rash, No bruises | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> | Hips: | <input type="checkbox"/> Full ROM, <input type="checkbox"/> Neg Barlow <input type="checkbox"/> Neg Ortolani | <input type="checkbox"/> Hip click <input type="checkbox"/> Hip clunk |
| <input type="checkbox"/> | Neuro: | <input type="checkbox"/> Normal tone/strength/symmetry | <input type="checkbox"/> |
| <input type="checkbox"/> | Genitalia: | <input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down B/L | <input type="checkbox"/> |
| <input type="checkbox"/> | Other findings: | <input type="checkbox"/> | <input type="checkbox"/> |

LABS/X-RAYS: Hip U/S Spine U/S

A/P: Well baby: normal growth & development for age
 400 IU Vitamin D supplement/day Infant Multivitamin 1 ml per day Triple paste to diaper area Q diaper change

F/U: at next well child visit at ___ months, or sooner if parental concerns
 Patient and/or parent verbalizes understanding of treatment and plan
 Anticipatory guidance/Prevention handout provided



Ages & Stages Questionnaires®

9

9 months 0 days through 9 months 30 days

Month Questionnaire



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby:
 Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

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"/> | — |
|  | | | | |

GROSS MOTOR (continued)

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?



| YES | SOMETIMES | NOT YET | ___ |
|-----------------------|-----------------------|-----------------------|-----|
| <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"/> | ___ |
|-----------------------|-----------------------|-----------------------|-----|

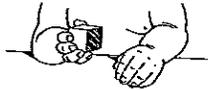
6. Does your baby walk beside furniture while holding on with only one hand?

| | | | |
|-----------------------|-----------------------|-----------------------|-----|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
|-----------------------|-----------------------|-----------------------|-----|

GROSS MOTOR TOTAL ___

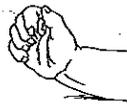
FINE MOTOR

1. Does your baby pick up a small toy with only one hand?



| YES | SOMETIMES | NOT YET | ___ |
|-----------------------|-----------------------|-----------------------|-----|
| <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."

PROBLEM SOLVING

1. Does your baby pass a toy back and forth from one hand to the other?

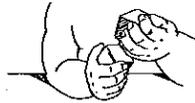


YES

SOMETIMES

NOT YET

2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?



3. When holding a toy in his hand, does your baby bang it against another toy on the table?



4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?

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)?

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.)

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

1. While your baby is on her back, does she put her foot in her mouth?



YES

SOMETIMES

NOT YET

2. Does your baby drink water, juice, or formula from a cup while you hold it?

3. Does your baby feed himself a cracker or a cookie?

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.)

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?

6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?

PERSONAL-SOCIAL TOTAL

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

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



9 Month ASQ-3 Information Summary

9 months 0 days through
9 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

| Area | Cutoff | Total Score | 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 |
|-----------------|--------|-------------|---|---|----|----|----|----|----|----|----|----|----|----|----|
| Communication | 13.97 | | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Gross Motor | 17.82 | | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Fine Motor | 31.32 | | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Problem Solving | 28.72 | | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Personal-Social | 18.91 | | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|----------------------------------------------------------------|------------|-----------|------------------------------------------|-----|----|
| 1. Uses both hands and both legs equally well? Comments: | Yes | NO | 5. Concerns about vision? Comments: | YES | No |
| 2. Feet are flat on the surface most of the time? Comments: | Yes | NO | 6. Any medical problems? Comments: | YES | No |
| 3. Concerns about not making sounds? Comments: | YES | No | 7. Concerns about behavior? Comments: | YES | No |
| 4. Family history of hearing impairment? Comments: | YES | No | 8. Other concerns? Comments: | YES | No |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
 If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the baby's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- _____ Provide activities and rescreen in _____ months.
- _____ Share results with primary health care provider.
- _____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- _____ Refer to primary health care provider or other community agency (specify reason): _____
- _____ Refer to early intervention/early childhood special education.
- _____ No further action taken at this time
- _____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

| | 1 | 2 | 3 | 4 | 5 | 6 |
|-----------------|---|---|---|---|---|---|
| Communication | | | | | | |
| Gross Motor | | | | | | |
| Fine Motor | | | | | | |
| Problem Solving | | | | | | |
| Personal-Social | | | | | | |



Questions about your child's development?

Educational & Developmental Intervention Services (EDIS)

is a program for infants and toddlers (birth to 36 months) who have:

- medical conditions which may affect development (such as complications of prematurity, hearing or visual impairment)
- developmental delay (for example, not walking or talking as expected) or atypical development
- genetic conditions

Educational & Developmental Intervention Services provides:

- in-home services
- basic services are free to eligible children:
 - * developmental evaluation (includes physical, communication, problem-solving, self-help, and social-emotional skills)
 - * in-home training for parents on encouraging child's development
 - * service coordination (helps parents access other services)

Parents can refer their children!

To make a referral, call:

(for families living on base:))

**Educational & Developmental
Intervention Services**
Location: NH200 Annex
Naval Hospital Camp Lejeune
Mailing Address:
EDIS
100 Brewster Blvd
Camp Lejeune, NC 28547
910 450 4127

(for families living off base:))

Children's Developmental Services Agency
2842 Neuse Blvd
New Bern, NC 28562
866 KIDS N NC (toll free)
866 543 7662