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 safe, trustworthy babysitters.
- If you feel unsafe in your home or have been hurt by someone, let us know; we can help.

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.

Your Changing and Developing Baby
- 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.
- 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 screen or 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
- 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.

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: 1-886-SEATCHECK; seatcheck.org

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Pediatric Worksheet Newborn to 23 Month Visit

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)

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<thead>
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<th>BP</th>
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<th>L 20/</th>
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<tr>
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<td></td>
<td>HC</td>
<td>0 No Hurt 1 Hurt Little 2 Hurt More 3 Hurt Been More 4 Hurt Whole Lot</td>
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(Please complete information below: if filled out before, list only changes since the last visit.)

**Chronic Medical Conditions** (Circle all that apply)
- NO Medical Conditions
- Asthma
- Diabetes
- Hayfever/Allergies
- Other:

**Surgeries/Hospitalizations** (Dates) (Circle all that apply)
- NO History of Surgeries
- Ear Tubes
- Tonsillectomy
- Adenoidectomy
- Appendectomy
- Circumcision
- Other:

**Family History**—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)
- 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:

**Medicines** (PLEASE INCLUDE DOSAGE)
- Please list all prescribed medications including supplements, herbs and vitamins obtained Over the Counter
- □ Infant Multivitamin 1 ml per day

**BIRTH HISTORY**—Complete for AGES NEWBORN TO 2 YEARS

Place of Birth: ___________________________

Birth weight: ________ lb ________ oz # 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 Phototheraphy □ Yes □ No Hip Click/Clunk □ Yes □ No
- Other: ___________________________

Did your child receive the Hepatitis B vaccine at birth? □ Yes □ No □ Unsure

**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)

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Is your child in day care? □ 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: Did a family member or contact have tuberculosis?

□ Yes □ No □ Unsure: Did a family member have 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 a history 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 a learning/reading 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/MI Care?

**PLEASE PROVIDE A GOOD CONTACT NUMBER:**

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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

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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

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(This section NOT for patient use)

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Treatment orders for this visit: Ensure patient's name and last four on front of document:

□ Flu Swab □ Ear Irrigation □ CBC □ Chol Panel □ Bilirubin (T/D) □ CXR

□ RSV Swab □ Left □ Right □ QA □ HbA1c □ TSBill □ EKG

□ Strep Screen/TCx □ Saline Bulb Suction □ CRP/ESR □ TSH, T4 □ Monopet

□ Tussin Swab □ Motrin (PO) □ mg □ BMP □ Iron Profile □ EBV Titers

□ Dex □ Tylenol (PO) □ mg □ CMP □ Lead

□ EVALUATE FOR VACCINE UPDATE □ PPD □ Other

□ Immunizations: 2 Month: Pediarix (DTaP, IPV-HepB), Hib, PCV-13, Rotarix

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<table>
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<th>1 Week (3-5 days)</th>
<th>1 MONTH</th>
<th>2 MONTH</th>
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<tbody>
<tr>
<td>COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)</td>
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<td>COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)</td>
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If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:

- **Eats well**
- **Follows your face**
- **Turns and calms to your voice**
- **Can suck, swallow and breathe easy**
- **Has started to smile**
- **Recognizes voice of parents**
- **Follows parents with eyes**
- **Able to lift head when on tummy**
- **Lifts head and begins to push up when prone**
- **Generates head erect for short period (when held upright)**
- **Symmetrical movements**
- **Indicates boredom when no activity change**
- **Different crying for different needs**
- **Smiles**
- **Looks for parents**
- **Self-comfort**

<table>
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<th>4 MONTH</th>
<th>6 MONTH</th>
<th>9 MONTH</th>
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<tr>
<td>COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)</td>
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<td><em><strong>COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)</strong></em></td>
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</tbody>
</table>

If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:

- **Pushes chest to elbows**
- **Good Head control**
- **Symmetry in movements**
- **Begins to roll and reach for objects**
- **Responds to affection**
- **Indicates pleasure or displeasure**
- **Spontaneous expressive babbling**
- **Social smile**
- **Efforts social interactions**
- **Smiles spontaneously**
- **Can calm down on own**
- **Sits briefly, leaning forward**
- **Rolls over**
- **Uses visual exploration**
- **Beginning to use oral exploration**
- **Uses a string of vowels (ah, eh, oh)**
- **Beginning to recognize own name**
- **Enjoys vocal turn taking**
- **Shows pleasure from interaction with parents or others**
- **Sits well**
- **Crawls**
- **Pulls to feet with support**
- **Peekaboo**
- **Objects permanence**
- **Looks at book**
- **Imitates sounds**
- **Points out objects**
- **Stranger anxiety**
- **Seeks parent for comfort**

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<th>12 MONTH</th>
<th>15 MONTH</th>
<th>18 MONTH</th>
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<td>COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)</td>
<td><em><strong>COMPLETE ATTACHED M-CHAT-R</strong></em> <em><strong>AGES AND STAGES QUESTIONNAIRE (ASQ)</strong></em></td>
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</table>

If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:

- **Waves bye-bye**
- **Tries to do what you do**
- **Cries when you leave**
- **Plays Peekaboo**
- **Holds a book to read**
- **Speaks 1-2 words**
- **Babbles**
- **Tries to make the same sound you do**
- **Looks at things you are looking at**
- **Follows simple directions**
- **Bangs toys together**
- **Helps in the house**
- **Laughs in response to others**
- **Speaks 6 words**
- **Knows names of favorite books**
- **Points to 1 body part**
- **Stacks 2 small blocks**
- **Runs**
- **Walks up steps**
- **Uses spoon and cup without spilling most of the time**
- **Drinks from cup with very little spilling**
**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**DATE**

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

☐ AHITA 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.

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

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

**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

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Date ASQ completed: ____________________________

Baby's information

Baby's first name: ____________________________ Middle initial: ______ Baby's last name: ____________________________

If baby was born 3 or more weeks prematurely, # of weeks premature: ____________________________

Baby's date of birth: ____________________________

Baby's gender:   ○ Male   ○ Female

Person filling out questionnaire

First name: ____________________________ Middle initial: ______ Last name: ____________________________

Relationship to baby:   ○ Parent   ○ Guardian   ○ Teacher   ○ Child care provider

  ○ Grandparent or other relative

  ○ Foster parent

  ○ Other: ____________________________

Street address: ____________________________

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: ____________________________
### 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

1. Does your baby make sounds like “da,” “ga,” “ka,” and “ba”?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

3. Does your baby make two similar sounds like “ba-ba,” “da-da,” or “ga-ga”? (The sounds do not need to mean anything.)  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

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,” “Peekaboo,” “clap your hands,” “So Big”)?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

5. Does your baby follow one simple command, such as “Come here,” “Give it to me,” or “Put it back,” without your using gestures?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

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.)  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

**COMMUNICATION TOTAL**  

### GROSS MOTOR

1. If you hold both hands just to balance your baby, does she support her own weight while standing?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

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*Note: ASQ3: 9 Month Questionnaire, 9 months 0 days through 9 months 30 days. Important Points to Remember include trying each activity with your baby before marking a response, making completing the questionnaire a fun game, ensuring your baby is rested and fed, and returning the questionnaire by a specified date.*
### 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**

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?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

6. Does your baby walk beside furniture while holding on with only one hand?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**  

### FINE MOTOR

1. Does your baby pick up a small toy with only one hand?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

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.)  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

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.)  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

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.)  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

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.  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?  
   - **YES**  
   - **SOMETIMES**  
   - **NOT YET**

**FINE MOTOR TOTAL**

- **YES**
- **SOMETIMES**
- **NOT YET**

*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?  
   - YES  
   - SOMETIMES  
   - NOT YET

3. When holding a toy in his hand, does your baby bang it against another toy on the table?  
   - YES  
   - SOMETIMES  
   - NOT YET

4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?  
   - YES  
   - SOMETIMES  
   - NOT YET

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)?  
   - YES  
   - SOMETIMES  
   - NOT YET

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.)  
   - YES  
   - SOMETIMES  
   - NOT YET

### PROBLEM SOLVING TOTAL

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## 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?  
   - YES  
   - SOMETIMES  
   - NOT YET

3. Does your baby feed himself a cracker or a cookie?  
   - YES  
   - SOMETIMES  
   - NOT YET

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.)  
   - YES  
   - SOMETIMES  
   - NOT YET

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?  
   - YES  
   - SOMETIMES  
   - NOT YET

6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?  
   - YES  
   - SOMETIMES  
   - NOT YET

### 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

   [Blank space for explanation]

8. Does anything about your baby worry you? If yes, explain:
   ☐ YES  ☐ NO

   [Blank space for explanation]
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.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cutoff</th>
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1. Uses both hands and both legs equally well? Yes NO
   Comments:

2. Feet are flat on the surface most of the time? Yes NO
   Comments:

3. Concerns about not making sounds? YES No
   Comments:

4. Family history of hearing impairment? YES No
   Comments:

5. Concerns about vision? YES No
   Comments:

6. Any medical problems? YES No
   Comments:

7. Concerns about behavior? YES No
   Comments:

8. Other concerns? YES No
   Comments:

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).

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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