FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Patrick B. Johansing, DO | Shara M. Salverda, FNP | Jessica L. Oltman, FNP-C | Dawn R. Headings, FNP- BC
John R. Adair, PA-C | Maria A Faaeteete, FNP-C | Jadie A. Dolan, FNP-C

PEDIATRIC HEALTH MAINTENANCE – 6 MONTHS
PATIENT QUESTIONNAIRE

General

Do you have any concerns about your baby? Yes___ No___

If "yes," please specify:

____

Is your child in daycare or in the care of a babysitter? Yes___ No___

Do your child's eyes ever appear to cross or drift apart? Yes___ No___

Is there a family history of "lazy eye?" Yes___ No___

Feeding and Sleeping

What do you feed your baby? ☐ Breastmilk ☐ Formula (brand/type: _______________)

Ounces per feeding (if bottle fed): __________ oz.

My baby feeds every ___ hours during the day and wakes up ___ times during the night to feed.

Are you giving your baby any vitamins? ☐ No ☐ Vitamin D ☐ Other

Has your baby started solid foods? Yes___ No___

Is there fluoride in your water? Yes___ No___

Do you think your baby's bowel movements are normal? Yes___ No___

Does your baby sleep through the night? Yes___ No___

Environment

What type of housing do you have? ☐ House ☐ Apartment ☐ Manufactured Home

What year was your home built? ____________

Who lives with you in your home? ____

Do you have pets? Yes___ No___

Does anyone smoke in your house? Yes___ No___

Safety

Does your home have functioning smoke detectors? Yes___ No___

Is your water heater turned down below 120 degrees? Yes___ No___

Does your baby ride in a rear-facing car seat, in the back seat? Yes___ No___

Do you leave your baby alone on the changing table, sofa, or bed? Yes___ No___

How have you 'baby-proofed' your home? ____

Are you afraid of your partner or anyone close to you? Yes___ No___

Do you feel overly stressed or unsupported? Yes___ No___

Patient Name: ____

Completed by (name and relationship to patient: ___________________________ Date: ________

Ages & Stages Questionnaires®

6 Month Questionnaire

5 months 0 days through 6 months 30 days

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: ____________

P101060100

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6 Month Questionnaire

5 months 0 days through 6 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 high-pitched squeals?	○	○	○	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	○	○	○	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___
			COMMUNICATION TOTAL	___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	○	○	○	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	○	○	○	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	___
4. When you put your baby on the floor, does she lean on her hands while sitting? *(If she already sits up straight without leaning on her hands, mark "yes" for this item.)*	○	○	○	___

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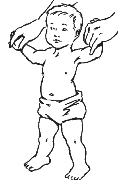
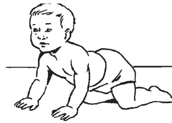
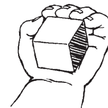
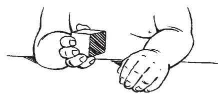
GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. If you hold both hands just to balance your baby, does he support his own weight while standing? 	○	○	○	___
6. Does your baby get into a crawling position by getting up on her hands and knees? 	○	○	○	___
		GROSS MOTOR TOTAL		___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	○	○	○	___
2. Does your baby reach for or grasp a toy using both hands at once?	○	○	○	___
3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)*	○	○	○	___
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it? 	○	○	○	___
5. Does your baby *try* to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? *(If he already picks up the crumb or Cheerio, mark "yes" for this item.)*	○	○	○	___
6. Does your baby pick up a small toy with only one hand? 	○	○	○	___
		FINE MOTOR TOTAL		___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
				___

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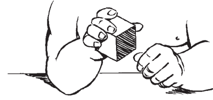
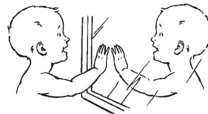
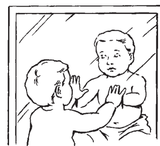
PROBLEM SOLVING *(continued)*

		YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth?		○	○	○	___
5. Does your baby pass a toy back and forth from one hand to the other?		○	○	○	___
6. Does your baby play by banging a toy up and down on the floor or table?		○	○	○	___
			PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL

		YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself?		○	○	○	___
2. Does your baby act differently toward strangers than he does with you and other familiar people? *(Reactions to strangers may include staring, frowning, withdrawing, or crying.)*		○	○	○	___
3. While lying on her back, does your baby play by grabbing her foot?		○	○	○	___
4. When in front of a large mirror, does your baby reach out to pat the mirror?		○	○	○	___
5. While your baby is on his back, does he put his foot in his mouth?		○	○	○	___
6. Does your baby try to get a toy that is out of reach? *(She may roll, pivot on her tummy, or crawl to get it.)*		○	○	○	___
			PERSONAL-SOCIAL TOTAL		___

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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

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6. Has your baby had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

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

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6 Month ASQ-3 Information Summary

5 months 0 days through 6 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	29.65		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Gross Motor	22.25		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	25.14		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Problem Solving	27.72		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Personal-Social	25.34		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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? 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).

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

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Well Child: 6 Months

Name: ____________________________ Date: __________ Length: _________ in. (______ %)

Weight: ______ lbs. ______ oz. (_____ %) Head Circumference: ___________ cm. (______ %)

IMMUNIZATIONS: Hep B (3rd dose), Rotovirus (3rd dose), DtaP (3rd dose), Hib (3rd dose), PCV 13 (3rd dose), Polio (3rd dose). May get Influenza vaccination if in season (2 doses are needed).

IBUPROFEN (Advil, Motrin) & ACETAMINOPHEN (Tylenol) DOSAGE

Child's Weight	Ibuprofen Infant Dose (50 mg/1.25mL)	Acetaminophen Infant's Suspension (160mg/5mL)
6-12lbs	X	1.25mL
12-18lbs	1.25mL	2.5mL
18-24lbs	1.875mL	3.75mL (3/4 tsp)
24-28lbs	1.25mL + 1.25mL	5mL (1 tsp)
Over 28lbs	1.875mL + 1.25mL	5mL (1 tsp)

Ibuprofen may be given every 6 hours, but not more than 4 times in 24 hours. CHECK THE CONCENTRATION OF THE IBUPROFEN YOU ARE USING

Acetaminophen may be given every 4 hours, but not more than four times in 24 hours. Please call the office if fever persists for more than 2 days or if you have any questions.

NEXT VISIT: 9 months

How Your Family is Doing:

- If you are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and SNAP can also provide information and assistance.
- Don't smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy.
- Don't use alcohol or drugs.
- Choose a mature, trained, and responsible babysitter or caregiver.
- Ask us questions about child care programs.
- Talk with us or call for help if you feel sad or very tired for more than a few days.
- Spend time with family and friends.

Your Changing and Developing Baby

- Place your baby so they are sitting up and can look around.
- Talk with your baby by copying the sounds they make.
- Look at and read books together.
- Play games such as peekaboo, patty-cake, and so big.
- Don't have a TV on in the background or use a TV or other digital media to calm your baby.
- If your baby is fussy, give them safe toys to hold and put into their mouth. Make sure they are getting regular naps and playtimes.

Discipline

- Ask us about the need for fluoride.
- Clean gums and teeth (as soon as you see the first tooth) 2 times per day with a soft cloth or soft toothbrush and a small smear of fluoride toothpaste (no more than a grain of rice).
- Don't give your baby a bottle in the crib. Never prop the bottle.
- Don't use foods or juices that your baby sucks out of a pouch.
- Don't share spoons or clean the pacifier in your mouth.

American Academy of Pediatrics, "Bright Futures Parent Handout 6 Month – English," https://pediatrics.christieclinic.com/wp-content/uploads/2019/11/parent-handouts-6-month-english.pdf

Feeding Your Baby

- Know that your baby's growth will slow down.
- Be proud of yourself if you are still breastfeeding. Continue as long as you and your baby want.
- Use an iron-fortified formula if you are formula feeding.
- Begin to feed your baby solid food when they are ready.
- Look for signs your baby is ready for solids. They will open their mouth for the spoon, sit with support, show good head and neck control, and be interested in foods you eat.
- Introduce one new food at a time.
- Use foods with good sources of iron and zinc, such as iron- and zinc-fortified cereal and pureed red meat, such as beef or lamb.
- Introduce fruits and vegetables after your baby eats iron- and zinc-fortified cereal or pureed meat well.
- Offer solid food 2 to 3 times per day; let your baby decide how much to eat.
- Avoid raw honey or large chunks of food that could cause choking.
- Consider introducing all other foods, including eggs and peanut butter, because research shows they may actually prevent individual food allergies.
- To prevent choking, give your baby only very soft, small bites of finger foods.
- Wash fruits and vegetables before serving.
- Introduce your baby to a cup with water, breast milk, or formula.
- Avoid feeding your baby too much; follow baby's signs of fullness, such as
    - Leaning back
    - Turning away
- Don't force your baby to eat or finish foods.
    - It may take 10 to 15 times of offering your baby a type of food to try before they like it.

Safety

- Use a rear-facing–only car safety seat in the back seat of all vehicles.
- Never put your baby in the front seat of a vehicle that has a passenger airbag.
- If your baby has reached the maximum height/weight allowed with your rear-facing–only car seat, you can use an approved convertible or 3-in-1 seat in the rear-facing position.
- Put your baby to sleep on their back.
- Choose crib with slats no more than 2 3⁄8 inches apart. Lower the crib mattress all the way.
- Don't use a drop-side crib.
- Don't put soft objects and loose bedding such as blankets, pillows, bumper pads, and toys in the crib.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Do a home safety check (stair gates, barriers around space heaters, and covered electrical outlets).
- Don't leave your baby alone in the tub, near water, or in high places such as changing tables, beds, and sofas.
- Keep poisons, medicines, and cleaning supplies locked and out of your baby's sight and reach.
- Keep your baby in a high chair or playpen while you are in the kitchen.
- Do not use a baby walker.
- Keep small objects, cords, and latex balloons away from your baby.
- Keep your baby out of the sun. When you do go out, put a hat on your baby and apply sunscreen with SPF of 15 or higher on their exposed skin.
- **IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222**

WHAT TO EXPECT AT YOUR CHILD'S 9 MONTH VISIT

We will talk about:

- Caring for your baby, your family, and yourself
- Teaching and playing with your baby
- Disciplining your baby
- Introducing new foods and establishing a routine
- Keeping your baby safe at home and in the car

American Academy of Pediatrics, "Bright Futures Parent Handout 9 Month – English," https://pediatrics.christieclinic.com/wp-content/uploads/2019/11/parent-handouts-9-month-english.pdf