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 – 9 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.

What is your feeding routine? _____

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

What are some solid foods your baby eats? _____

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? _____

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

Are your windows locked? Are any guns in your home securely stored? Yes___ No___

Do you have a pool? Yes___ No___

Do you have pets? Yes___ No___

Does anyone smoke in your house? Yes___ No___

Safety

Are small objects kept out of your baby's reach at all times? Yes___ No___

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

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: _____

ASQ-3 Ages & Stages Questionnaires®

9 months 0 days through 9 months 30 days

9 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: _____

P101090101

ASQ-3™

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"?	◯	◯	◯	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	◯	◯	◯	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	◯	◯	◯	___
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")?	◯	◯	◯	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," ***without*** your using gestures?	◯	◯	◯	___
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.)*	◯	◯	◯	___
			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? 	◯	◯	◯	___
2. When sitting on the floor, does your baby sit up straight for several minutes ***without*** using his hands for support? 	◯	◯	◯	___

E101090201

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? 	○	○	○	___
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? 	○	○	○	___
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	○	○	○	___
6. Does your baby walk beside furniture while holding on with only one hand?	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand? 	○	○	○	___
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.)* 	○	○	○	___
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.)* 	○	○	○	___
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.)* 	○	○	○	___
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. 	○	○	○	___ *
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	○	○	○	___

FINE MOTOR TOTAL ___

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

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
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

	YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth? 	○	○	○	___
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? 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						

P101090701

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

Well Child: 9 Months

Name: _____ Date: _____ Length: _____ in. (_____ %)

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

IMMUNIZATIONS: If up to date, none routinely other than influenza vaccination in season

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: 12 months

Feeding Your Baby

- Be patient as your child learns to eat without help.
- Messy eating is normal.

DO:

- Emphasize healthy foods.
- Give 3 meals and 2-3 snacks a day.
- Start giving more table foods.
- Keep trying new foods.
- Vary thickness and texture of food.
- Continue to offer breast milk or formula until 12 months.
- Let your baby decide when they are full.

DON'T:

- Give food that are choking hazards (ex. raw apple, nuts, large chunks).
- Give high allergen foods (ex. honey, egg whites, citrus, milk, strawberry).
- Switch to cow milk until 12 months.
- Give them soda, tea, coffee, etc.

Your Changing and Developing Baby

- Keep daily routines for your baby.
- Let your baby explore inside and outside the home. Be with them to keep them safe and feeling secure.
- Be realistic about their abilities at this age.
- Recognize that your baby is eager to interact with other people but will also be anxious when separated from you. Crying when you leave is normal. Stay calm.
- Support your baby's learning by giving them baby balls, toys that roll, blocks, and containers to play with.
- Help your baby when they need it.
- Talk, sing, and read daily.
- Don't allow your baby to watch TV or use computers, tablets, or smartphones. TV and videos, even if labeled as "educational" programs, are not recommended and do not help your baby's development. No screen time is recommended before the age of 2. The human voice is the best stimulant for developing infant brains.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.

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

Safety

▪ Consistent messages are vital. If an object is a potential danger, say "no," take object away, and replace with a safe substitute. Show your child what to do, not just what not to do.
▪ Your child has a short memory. Do not expect learning to occur after just one or two incidents.
▪ Increased mobility provides a bigger challenge for you to keep your child safe. **THOROUGHLY CHILD-PROOF YOUR HOME.**
▪ Place gates at the top and bottom of stairs.
▪ Don't leave hot or heavy things on tablecloths that your child could pull over.
▪ Put barriers around space heaters and keep electrical cords out of reach.
▪ Install operable window guards on windows at the second story or higher.
▪ Keep furniture away from windows.
▪ Put your baby in a high chair or playpen when in the kitchen.
▪ If you keep a gun at home, store it unloaded and locked up with the ammunition locked separately.
▪ Always use a properly fitted rear-facing car seat. The center rear seat is safest. If they outgrow their car seat, get a larger one. They should remain rear-facing until they reach the highest height or weight allowed by the manufacturer. This will normally be past their second birthday.
▪ Your baby's safety depends on you. Always wear a seat belt; never drive under the influence; and never use your phone while driving.
▪ Never leave your baby in the car alone.
▪ Never leave your baby in or near water alone.
▪ Keep poisonous substances locked up and out of reach.
▪ **IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222**

How Your Family is Doing:

▪ If you feel unsafe in your home or have been hurt by someone, let us know. Hotlines and community agencies can also provide confidential help.
▪ Keep in touch with friends and family.
▪ Invite friends over or join a parent group.
▪ Take time for yourself and with your partner.

Discipline

▪ Kindly tell your baby what to do (ex. "Time to eat"), rather than what not to do.
▪ Be consistent.
▪ Use distraction at this age. Sometimes you can change what your baby is doing by offering something else such as a favorite toy.
▪ Do things the way you want your baby to do them—you are your baby's role model.
▪ Use "No!" only when your baby is going to get hurt or hurt others.

WHAT TO EXPECT AT YOUR CHILD'S 12 MONTH VISIT

We will talk about

▪ Caring for your child, your family, and yourself
▪ Creating daily routines
▪ Feeding your child
▪ Caring for your child's teeth
▪ Keeping your child safe at home, outside, and in the car