Well child

Pre-visit questionnaire

9 month

valid 9m 0d – 11m 31d

General

1.	List any concerns you want to discuss today:			
2.	Does your baby ever appear cross-eyed?	No	Yes	
3.	Does your baby have screen time (smartphone, tablet, TV)?	No	Yes	

Nutrition

4.	Is your baby breastfeeding?	Yes	No	
5.	Is your baby getting formula?	Yes	No	
	a. Which formula do you use?			
6.	Have you introduced baby foods, including common allergens like eggs, peanuts, tree nuts, soy, dairy, fish, or shellfish? (These should be given in a form that your baby will not choke on, like peanut butter or pureed shellfish.)	Yes	No	
7.	Does your baby eat foods containing iron? (Examples: turkey, prunes, beans, spinach, broccoli, whole grain, or more than 32 ounces per day of formula.)	Yes	No	
8.	Is your baby getting 2-3 meals of solid foods per day?	Yes	No	
9.	Is your baby getting an infant multivitamin or a vitamin D supplement? (If you baby is taking more than 32 ounces of formula per day, you do not need to give a supplement.)	Yes	No	
10.	Does your baby drink juice or other sweetened drinks?	No	Yes	
11.	Does your baby have any problems with bowel movements (poop)?	No	Yes	

Oral health

12.	Does your baby fall asleep with a bottle in the mouth?	No	Yes	
13.	Does your baby wake at night to eat?	No	Yes	Sometimes
14.	Are you using a soft toothbrush or cloth with fluoridated toothpaste (size of a grain of rice) to clean your baby's teeth and gums?	Yes	No	No teeth yet
15.	Does your water contain fluoride, or is your child on a fluoride supplement?	Yes	No	Not sure

Lead

16. Is your baby regularly in a house built before 1978?	No	Yes	
17. Does your baby have a brother, sister or playmate who had lead poisoning?	No	Yes	

Tuberculosis

18. Is your child at risk for infection with tuberculosis? (Includes children born in Africa, Asia, Latin America, or eastern Europe; children who have stayed with family in one of those places for more than a week, or if exposed to anyone with active TB.)	No	Yes	Not sure

Safety checklist

Check all that apply.

	True	I have questions
19. I always stay close enough to touch my baby when they are in the bath.	☐	☐
20. My baby does not wear jewelry.	☐	☐
21. My baby rides in a rear-facing safety seat, in the back seat.	☐	☐
22. We have working smoke/carbon monoxide detectors at home.	☐	☐
23. We apply sunscreen if out in the sun for longer than 15-30 minutes.	☐	☐
24. We don't have a seated infant walker with wheels (or we do, but the baby has no access to stairs).	☐	☐

SWYC

Survey of Well-Being in Young Children

9 month

valid 9m 0d – 11m 31d

Developmental milestones

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. Please be sure to answer all the questions.

		Not yet	Somewhat	Very much
25.	*Holds up arms to be picked up*	☐	☐	☐
26.	*Gets into a sitting position by him or herself*	☐	☐	☐
27.	*Picks up food and eats it*	☐	☐	☐

		Not yet	Somewhat	Very much
28.	*Pulls up to standing*	☐	☐	☐
29.	*Plays games like "peek-a-boo" or "pat-a-cake"*	☐	☐	☐
30.	*Calls you "mama" or "dada" or a similar name*	☐	☐	☐
31.	*Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"*	☐	☐	☐
32.	*Copies sounds that you make*	☐	☐	☐
33.	*Walks across a room without help*	☐	☐	☐
34.	*Follows directions, like "Come here" or "Give me the ball"*	☐	☐	☐

BPSC — Baby Pediatric Symptom Checklist

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very much
35.	Does your child have a hard time being with new people?	☐	☐	☐
36.	Does your child have a hard time in new places?	☐	☐	☐
37.	Does your child have a hard time with change?	☐	☐	☐
38.	Does your child mind being held by other people?	☐	☐	☐
39.	Does your child cry a lot?	☐	☐	☐
40.	Does your child have a hard time calming down?	☐	☐	☐
41.	Is your child fussy or irritable?	☐	☐	☐
42.	Is it hard to comfort your child?	☐	☐	☐
43.	Is it hard to keep your child on a schedule or routine?	☐	☐	☐
44.	Is it hard to put your child to sleep?	☐	☐	☐
45.	Is it hard to get enough sleep because of your child?	☐	☐	☐
46.	Does your child have trouble staying asleep?	☐	☐	☐

Parent concerns	Not at all	Somewhat	Very much
47. Do you have concerns about your child's learning or development?	☐	☐	☐
48. Do you have any concerns about your child's behavior?	☐	☐	☐

Family questions *Because family members can have a big impact on your child's development, please answer a few questions about your family below:*	No	Yes
49. Does anyone who lives with your child smoke tobacco?	☐	☐
50. In the last year, have you ever drunk alcohol or used drugs more than you meant to?	☐	☐
51. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐	☐
52. Has a family member's drinking or drug use ever had a bad effect on your child?	☐	☐

	Never true	Sometimes true	Often true
53. Within the past 12 months, we worried whether our food would run out before we got money to buy more.	☐	☐	☐

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
54. Having little interest or pleasure in doing things?	☐	☐	☐	☐
55. Feeling down, depressed or hopeless?	☐	☐	☐	☐

	No tension	Some tension	A lot of tension	Not applicable
56. In general, how would you describe your relationship with your spouse/partner?	☐	☐	☐	☐

	No difficulty	Some difficulty	Great difficulty	Not applicable
57. Do you and your partner work out arguments with:	☐	☐	☐	☐

58. During the past week, how many days did you or other family members read to your child?

0 1 2 3 4 5 6 7