CASTLE VALLEY CHILDRENS' CLINIC

Health Maintenance Visit

9 MO - 12 MO

Patient Name________________________________

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO THE DOUBLE LINE (please circle and check appropriate answers

NUTRITION

1. Are you breastfeeding or bottlefeeding your baby now? Breast Bottle
2. Has your baby started to use a cup yet? yes no
3. Are you giving your baby vitamins, iron or fluoride? yes no
4. Please check kind of food and approximately how much your baby eats:

Milk ____	Amount in a bottle ________	Amount in a cup ________	
Juice____	Amount ________	Vegetables____	Amount ________
Cereal____	Amount ________	Meats________	Amount ________
Fruits ____	Amount________	Snacks______	What kind? ________

5. Does your child feed himself/herself finger foods? yes no
6. Is your baby having any problems with eating? yes no
7. Is your child on WIC or Denver Food Supplemental Program? yes no

ELIMINATION

8. Have you notice a strong or unusual smell of your child's urine? yes no
9. Has your child had any problems with constipation or diarrhea? yes r

BEHAVIOR

10. Is your child having any problems with sleeping? yes no
11. How many hours does your baby sleep at night? __________ hours
12. How many naps does he/she take? __________ naps
13. Does your child have any behaviors you would like to change? yes no
    List Behavior________________________________
14. Is there anything which upsets you or concerns you about your child? yes no
15. Does you feel you have a difficult child? yes no

DEVELOPMENT

16. All children learn things at different times. At this point in your child's development, check which of the following he/she can do.

______ Sit without support for a minute	______ Pull himself to standing position	______ Play peek-a-boo
______ Bang two cubes together	______ Stand alone	______ Say mama, dada
______ Creep or crawl	______ Walk, holding onto furniture	______ Play pat-a-cake

ILLNESS

17. Has your baby had any illnesses or needed to see a doctor since your last visit? yes no
18. If your child is on any medications, please name them: ________________________________

REVIEW OF SYSTEMS (Check if your child has any of the following since the last visit.)

____ Accidents/injury/unconsciousness	____Nasal congestion	____Allergies
____ Ear infection	____Trouble breathing	____ Skin rashes
____ Hearing problems	____Frequent colds or coughing	____ Big weight gain or loss
____ Eye infections or drainage	____ High fever	____ Recent weight gain or loss

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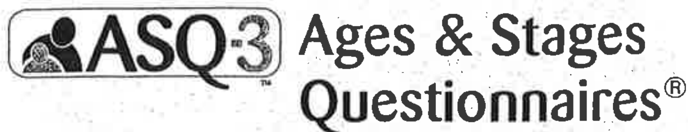
OBJECTIVE:

NURSING DIAGNOSIS:

PLAN: (Anticipatory guidance checklist on page 1)

PROVIDER SIGNATURE ________________________________



9 Month Questionnaire

9 months 0 days through 9 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: ______

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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 her the activity yourself (such as "bye-bye," "Peekaboo," "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?	○	○	○	—

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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."*

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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		—

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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

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

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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

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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						

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