



Well Child Check: 9 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

- Does your baby take any medications or supplements, including vitamins? No Yes: _____
- Does your baby have known allergies to foods/medicines? No Yes: _____
- Do you have concerns about your baby's hearing/vision? No Yes: _____
- Does your baby see any specialists outside of ORP? No Yes: _____
- Does your water contain fluoride? (City water contains fluoride) Yes No

Nutrition:

Does your baby drink breastmilk, iron fortified formula, or both? Breastmilk Formula Both

If you are giving your baby bottles, how many ounces does your child take in 24 hours? _____

Has your baby tried soft lumpy textures of foods (ex. mashed, chopped)? Yes No

What allergens they have tried (circle): dairy egg fish wheat peanut butter & nut butters

Does your baby...

Show several expressions like happy, sad, angry, surprised?	Yes	No
Become shy, clingy or fearful around strangers?	Yes	No
Look when you call his name?	Yes	No
React when you leave? (Looks, reaches, or cries for you)	Yes	No
Smile or laugh when you play peek a boo?	Yes	No
Make different sounds like mamamamama or bababababa?	Yes	No
Lift her arms to be picked up?	Yes	No
Look for objects when dropped out of sight? (like a spoon or toy)	Yes	No
Bang 2 things together?	Yes	No
Get to a sitting position by herself?	Yes	No
Sit without support?	Yes	No
Use his fingers to rake food towards himself?	Yes	No
Move things from one hand to the other hand?	Yes	No

Who lives at home with your child? _____

Are parents: single married divorced separated

Who takes care of your child during the day? _____

Have there been major changes lately in your baby's or family's life?

Do you have any international travel plans prior to your child's first birthday with your child?

If so, when and where? _____

Are you happy with your child's sleep?	Yes	No
Does anyone smoke or vape in your home?	No	Yes
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?	No	Yes
Does your baby play on a tablet or smartphone or watch TV?	No	Yes
Do you have a daily routine for feeding, naps, and bedtime?	Yes	No
Is your baby learning to go to sleep by himself?	Yes	No
Do you and your baby enjoy quiet activities such as reading, singing, or taking walks outside?	Yes	No
Does your baby drink from a cup?	Yes	No
Does your baby feed himself?	Yes	No
Do you let your baby decide how much to eat?	Yes	No
Does the baby always sleep in a crib or bassinet?	Yes	No
Is your baby fastened securely in a rear facing care seat in the back seat every time they ride in the car?	Yes	No
Do you always stay within arm's reach of your baby when on the changer, bed or in/near water?	Yes	No
Do you keep household cleaner, chemicals, and medicine locked up and out of your baby's sight and reach?	Yes	No
Do you have a gate at the top and bottom of all stairs in your home?	Yes	No
Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes



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"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
			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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				

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	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

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?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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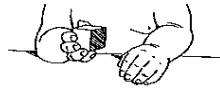
6. Does your baby walk beside furniture while holding on with only one hand?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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GROSS MOTOR TOTAL ___

FINE MOTOR

1. Does your baby pick up a small toy with only one hand?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

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.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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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.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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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.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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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.



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___*
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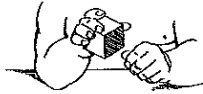
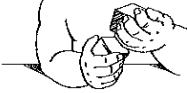

6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
3. When holding a toy in his hand, does your baby bang it against another toy on the table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your baby drink water, juice, or formula from a cup while you hold it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby feed himself a cracker or a cookie?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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

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?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. Other concerns?
Comments: | YES | No |

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						