OBERLIN ROAD PEDIATRICS

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? If yes, please list. □ No □ Yes: _____

Does your baby have known allergies to foods/medicines? If yes, please list. □ No □ Yes: _____

Do your have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does you 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 babababababa?	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 widowed
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

Name _____ DOB _____

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 her 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? 	○	○	○	___

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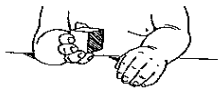
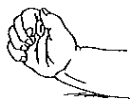
GROSS MOTOR *(continued)*

	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 ___

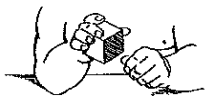
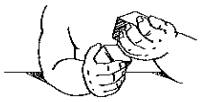
FINE MOTOR

	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."*

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? Yes ○ No ○
   If no, explain:

2. When you help your baby stand, are his feet flat on the surface most of the time? Yes ○ No ○
   If no, explain:

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? Yes ○ No ○
   If yes, explain:

4. Does either parent have a family history of childhood deafness or hearing impairment? Yes ○ No ○
   If yes, explain:

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 ○

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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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