

**9 Month Visit:**

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you.

Does your child sit without support?	Yes	No	Unsure
Can your child get herself up to stand?	Yes	No	Unsure
Does your child take steps holding on to furniture?	Yes	No	Unsure
Does your child pick up objects with the tips of the thumb and fingers?	Yes	No	Unsure
Does your child take finger foods?	Yes	No	Unsure
Does your child babble (talk with made up words/sounds)?	Yes	No	Unsure
Does your child make sounds such as "dada" or "mama"?	Yes	No	Unsure
Does your child understand a few words?	Yes	No	Unsure
Can you get your child to laugh?	Yes	No	Unsure
Does your child look for objects hidden or dropped out of view?	Yes	No	Unsure

Is your baby getting breastmilk, formula, or other milk?	Breastmilk	Formula	Other
If you are giving formula, how many ounces does your child take in 24 hours?	_____oz		
How much juice does your child drink in 24 hours?	_____oz		
Do you offer your child a cup or sippy cup everyday?	Yes	No	Unsure
Does your child sleep through the night?	Yes	No	Unsure
Is your home child-proofed?	Yes	No	Unsure
Do you usually use sunscreen for your child when outdoors?	Yes	No	Unsure

Do you have any other safety concerns in your home? Yes No Unsure  
 If so, what are your concerns? \_\_\_\_\_

Over the past 2 weeks, has mom ever felt down, depressed, or hopeless?	Yes	No	Unsure
Over the past 2 weeks, has mom felt little interest or pleasure in doing things?	Yes	No	Unsure

Who provides daytime care for your child? \_\_\_\_\_

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including vitamins? If so, please list them:

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? Yes No

***If so, what are your concerns?***