Name: Date of birth:								
Health Status Questio	nnaire	– 9 Mont	ths					
Baby lives with: mo	ther	father	both pare	nts	other:			
Childcare: daycare	baby	sitter st	ays at home	ot	her:			
Car seat use:	Y	N		Smok	e detectors:		Y	N
Sunscreen/protection:	Y	N		Fire e	xtinguishers	:	Y	N
<u>-</u>	Y				ms/guns in			
Home child proofed:	Y	N	Locked away:			Y	N	
-				Passiv	ve smoke ex	posure:	Y	N
Breastfeeding? Y N Formula feeding? Y	Every Formula:	_ hours	For	minu	ites per s	side		
J		OZ	every	hours	·,	_oz tota	al 24	hours
Solids/baby food? Y N Cereal Vegetables Fruit Any problems feeding? Y N								
Stool: regular irro	egular	hard	runny	soft				
Sleep problems: Y	N .							
Development concerns	: non	e speech	motor s	ocial	cognitive	vision	he	earing
Does your baby:								
Pull up to stand?					Y	N		
Stand holding on?					Y	N		
crawl?					Y	N		
Pick up small item with fingers?					Y	N		
Respond to name?					Y	N		
Babble and jabber (baby talk)?					Y	N		
Say "dada/mama" nonspecific?					Y	N		
Wave byebye?					Y	N		
Play "peekaboo"?					Y	N		
Do you have any conce	erns abo	out your ba	aby?					