

## Nine-Month-Old Well Child Visit

Baby's Name \_\_\_\_\_ Baby's Age \_\_\_\_\_ Date \_\_\_\_\_

Person completing the form \_\_\_\_\_ Relationship to the patient \_\_\_\_\_

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

<b>Nutrition:</b>	<b>Yes</b>	<b>No</b>
Is your baby feeding well?	( )	( )
Is your baby breastfed?	( )	( )
• If yes, how often? _____		
Is your baby formula fed? If yes:	( )	( )
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		
Is your baby starting to eat foods that need to be chewed?	( )	( )

<b>Family and Social History:</b>	<b>Yes</b>	<b>No</b>
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

<b>Preventative Health/Risk Factors:</b>	<b>Yes</b>	<b>No</b>
How many hours of TV or video is your child exposed to per day? _____		
Does your child always ride in a car seat, in the back seat, facing backwards?	( )	( )
Do you, anyone in your home, or anyone who cares for you child smoke?	( )	( )
Do any family members work with lead (car batteries, stained glass, lead solders, etc.)?	( )	( )
Do you live in a house built before 1978?	( )	( )

<b>Oral Health:</b>	<b>Yes</b>	<b>No</b>
Have you found a dentist for your child yet?	( )	( )

<b>Behavioral/Mental Health:</b>	<b>Yes</b>	<b>No</b>
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well, without snoring?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
• If yes, do you need assistance to find a suitable program?	( )	( )



# Ages & Stages Questionnaires®

## 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: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

Relationship to baby:  
 Parent  Guardian  Teacher  Child care provider  
 Grandparent or other relative  Foster parent  Other: \_\_\_\_\_

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:	



# 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:

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## 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," <i>without</i> 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 <i>without</i> using his hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				

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

**FINE MOTOR**

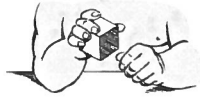
	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby <i>successfully</i> pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your baby pick up a small toy with the <i>tips</i> 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"/>	—
				
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"/>	—
				
5. Does your baby pick up a crumb or Cheerio with the <i>tips</i> 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"/>	— *
				
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"/>	—
	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? 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

**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