

9 Months Questions

Patient Name:

DOB:

Date:

Any questions or concerns today? Please circle all that apply.

Eating	Y	N
Elimination (voiding/stooling)	Y	N
Sleeping	Y	N
Developmental	Y	N
Hearing/Vision	Y	N
Skin	Y	N
Vaccines	Y	N
Other	Y	N
Any family changes or stressors since last visit?	Y	N
Does your baby have any exposure to smoke?	Y	N
Have you lowered your baby's crib mattress?	Y	N
Do you use a rear-facing car seat?	Y	N
Do you have the Poison Control phone number handy?	Y	N
Do you know what to do if your baby chokes?	Y	N
Do you have any concerns about how your baby acts around other people?	Y	N

Food Insecurity & Transportation Questions (mark your answer):

- Within the past 12 months, you worried that your food would run out before you got money to buy more.
 - Often true
 - Sometimes true
 - Never true
- Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
 - Often true
 - Sometimes true
 - Never true
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living (mark all that apply)?
 - Yes, it has kept me from medical appointments or getting medications
 - Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
 - No

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me |
| <input type="checkbox"/> As much as I always could | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual |
| <input type="checkbox"/> Definitely not so much now | <input type="checkbox"/> No, most of the time I have coped quite well |
| <input type="checkbox"/> Not at all | <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things | *7. I have been so unhappy that I have had difficulty sleeping |
| <input type="checkbox"/> As much as I ever did | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Rather less than I used to | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Definitely less than I used to | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> Hardly at all | <input type="checkbox"/> No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Yes, some of the time | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Not very often | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> No, never | <input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason | *9. I have been so unhappy that I have been crying |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Hardly ever | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Only occasionally |
| <input type="checkbox"/> Yes, very often | <input type="checkbox"/> No, never |
| *5. I have felt scared or panicky for no very good reason | *10. The thought of harming myself has occurred to me |
| <input type="checkbox"/> Yes, quite a lot | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No, not much | <input type="checkbox"/> Hardly ever |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Never |

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.



BRIGHT FUTURES HANDOUT ► PARENT

9 MONTH VISIT

Here are some suggestions from Bright Futures experts that may be of value to your family.

✓ HOW YOUR FAMILY IS DOING

- If you feel unsafe in your home or have been hurt by someone, let us know. Hotlines and community agencies can also provide confidential help.
- Keep in touch with friends and family.
- Invite friends over or join a parent group.
- Take time for yourself and with your partner.

✓ YOUR CHANGING AND DEVELOPING BABY

- Keep daily routines for your baby.
- Let your baby explore inside and outside the home. Be with her to keep her safe and feeling secure.
- Be realistic about her abilities at this age.
- Recognize that your baby is eager to interact with other people but will also be anxious when separated from you. Crying when you leave is normal. Stay calm.
- Support your baby's learning by giving her baby balls, toys that roll, blocks, and containers to play with.
- Help your baby when she needs it.
- Talk, sing, and read daily.
- Don't allow your baby to watch TV or use computers, tablets, or smartphones.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.

✓ DISCIPLINE

- Tell your baby in a nice way what to do ("Time to eat"), rather than what not to do.
- Be consistent.
- Use distraction at this age. Sometimes you can change what your baby is doing by offering something else such as a favorite toy.
- Do things the way you want your baby to do them—you are your baby's role model.
- Use "No!" only when your baby is going to get hurt or hurt others.

✓ FEEDING YOUR BABY

- Be patient with your baby as he learns to eat without help.
- Know that messy eating is normal.
- Emphasize healthy foods for your baby. Give him 3 meals and 2 to 3 snacks each day.
- Start giving more table foods. No foods need to be withheld except for raw honey and large chunks that can cause choking.
- Vary the thickness and lumpiness of your baby's food.
- Don't give your baby soft drinks, tea, coffee, and flavored drinks.
- Avoid feeding your baby too much. Let him decide when he is full and wants to stop eating.
- Keep trying new foods. Babies may say no to a food 10 to 15 times before they try it.
- Help your baby learn to use a cup.
- Continue to breastfeed as long as you can and your baby wishes. Talk with us if you have concerns about weaning.
- Continue to offer breast milk or iron-fortified formula until 1 year of age. Don't switch to cow's milk until then.

Helpful Resources: National Domestic Violence Hotline: 800-799-7233 | Family Media Use Plan: www.healthychildren.org/MediaUsePlan
Poison Help Line: 800-222-1222 | Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

9 MONTH VISIT—PARENT



SAFETY

- Use a rear-facing-only car safety seat in the back seat of all vehicles.
- Have your baby's car safety seat rear facing until she reaches the highest weight or height allowed by the car safety seat's manufacturer. In most cases, this will be well past the second birthday.
- Never put your baby in the front seat of a vehicle that has a passenger airbag.
- Your baby's safety depends on you. Always wear your lap and shoulder seat belt. Never drive after drinking alcohol or using drugs. Never text or use a cell phone while driving.
- Never leave your baby alone in the car. Start habits that prevent you from ever forgetting your baby in the car, such as putting your cell phone in the back seat.
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately.
- Place gates at the top and bottom of stairs.
- Don't leave heavy or hot things on tablecloths that your baby could pull over.
- Put barriers around space heaters and keep electrical cords out of your baby's reach.
- Never leave your baby alone in or near water, even in a bath seat or ring. Be within arm's reach at all times.
- Keep poisons, medications, and cleaning supplies locked up and out of your baby's sight and reach.
- Put the Poison Help line number into all phones, including cell phones. Call if you are worried your baby has swallowed something harmful.
- Install operable window guards on windows at the second story and higher. Operable means that, in an emergency, an adult can open the window.
- Keep furniture away from windows.
- Keep your baby in a high chair or playpen when in the kitchen.

WHAT TO EXPECT AT YOUR CHILD'S 12 MONTH VISIT

We will talk about

- Caring for your child, your family, and yourself
- Creating daily routines
- Feeding your child
- Caring for your child's teeth
- Keeping your child safe at home, outside, and in the car

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*

For more information, go to <https://brightfutures.aap.org>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this handout should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original handout included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

Inclusion in this handout does not imply an endorsement by the American Academy of Pediatrics (AAP). The AAP is not responsible for the content of the resources mentioned in this handout. Web site addresses are as current as possible but may change at any time.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this handout and in no event shall the AAP be liable for any such changes.

© 2019 American Academy of Pediatrics. All rights reserved.

Patient Name:

DOB:



10 Month Questionnaire

9 months 0 days
through 10 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 him 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	___

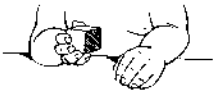




GROSS MOTOR

	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)*




	YES	SOMETIMES	NOT YET	
<p>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?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>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?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<p>6. Does your baby walk beside furniture while holding on with only one hand?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
GROSS MOTOR TOTAL				_____

FINE MOTOR


	YES	SOMETIMES	NOT YET	
<p>1. Does your baby pick up a small toy with only one hand?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>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? <i>(If she already picks up a crumb or Cheerio, mark "yes" for this item.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>3. Does your baby pick up a small toy with the <i>tips</i> of his thumb and fingers? <i>(You should see a space between the toy and his palm.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? <i>(The string may be attached to a toy.)</i></p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
<p>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.</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*
				
<p>6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?</p>	<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?	<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? <i>(Be sure the toy is completely hidden.)</i>	<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? <i>(If she already lets go of the toy into your hand, mark "yes" for this item.)</i>	<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

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

