

6 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 started childproofing your home? Check all that you have done.

Poisons/medications out of reach? Y N

Power cords out of reach? Y N

Outlets covered? Y N

Cabinet latches installed? Y N

Stairs gated? Y N

Irons/curling irons out of reach? Y N

Water heater thermostat set not above 120 degrees Fahrenheit? Y N

Poison Control phone number posted? Y N

Do you use sunscreen and bug spray? Y N

Do you know infant/child CPR? Y N

SEE REVERSE FOR ADDITIONAL QUESTIONS

6 Months Questions



Patient Name:

DOB:

Date:

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:

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input type="checkbox"/> Hardly ever<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<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

Patient Name: _____

DOB: _____



6 Month Questionnaire

5 months 0 days
through 6 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 high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. 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"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. When you put your baby on the floor, does she lean on her hands while sitting? <i>(If she already sits up straight without leaning on her hands, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____



GROSS MOTOR (continued)

5. If you hold both hands just to balance your baby, does he support his own weight while standing?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

6. Does your baby get into a crawling position by getting up on her hands and knees?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

GROSS MOTOR TOTAL ___

FINE MOTOR

1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. Does your baby reach for or grasp a toy using both hands at once?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? (If he already picks up a small object the size of a pea, mark "yes" for this item.)



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?



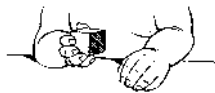
YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? (If he already picks up the crumb or Cheerio, mark "yes" for this item.)



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

6. Does your baby pick up a small toy with only one hand?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

1. When a toy is in front of your baby, does she reach for it with both hands?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. When your baby is on his back, does he turn his head to look for a toy when he drops it? (If he already picks it up, mark "yes" for this item.)

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

PROBLEM SOLVING

(continued)

4. Does your baby pick up a toy and put it in his mouth?



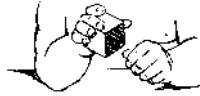
YES

SOMETIMES

NOT YET

☐
☐
☐

5. Does your baby pass a toy back and forth from one hand to the other?


☐
☐
☐

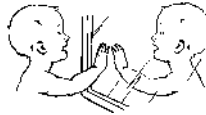
6. Does your baby play by banging a toy up and down on the floor or table?


☐
☐
☐

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

1. When in front of a large mirror, does your baby smile or coo at herself?



YES

SOMETIMES

NOT YET

☐
☐
☐

2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.)

☐
☐
☐

3. While lying on her back, does your baby play by grabbing her foot?


☐
☐
☐

4. When in front of a large mirror, does your baby reach out to pat the mirror?


☐
☐
☐

5. While your baby is on his back, does he put his foot in his mouth?


☐
☐
☐

6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)

☐
☐
☐

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

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



BRIGHT FUTURES HANDOUT ► PARENT

6 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 are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and SNAP can also provide information and assistance.
- Don't smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy.
- Don't use alcohol or drugs.
- Choose a mature, trained, and responsible babysitter or caregiver.
- Ask us questions about child care programs.
- Talk with us or call for help if you feel sad or very tired for more than a few days.
- Spend time with family and friends.

✓ YOUR BABY'S DEVELOPMENT

- Place your baby so she is sitting up and can look around.
- Talk with your baby by copying the sounds she makes.
- Look at and read books together.
- Play games such as peekaboo, patty-cake, and so big.
- Don't have a TV on in the background or use a TV or other digital media to calm your baby.
- If your baby is fussy, give her safe toys to hold and put into her mouth. Make sure she is getting regular naps and playtimes.

✓ FEEDING YOUR BABY

- Know that your baby's growth will slow down.
- Be proud of yourself if you are still breastfeeding. Continue as long as you and your baby want.
- Use an iron-fortified formula if you are formula feeding.
- Begin to feed your baby solid food when he is ready.
- Look for signs your baby is ready for solids. He will
 - Open his mouth for the spoon.
 - Sit with support.
 - Show good head and neck control.
 - Be interested in foods you eat.

Starting New Foods

- Introduce one new food at a time.
- Use foods with good sources of iron and zinc, such as
 - Iron- and zinc-fortified cereal
 - Pureed red meat, such as beef or lamb
- Introduce fruits and vegetables after your baby eats iron- and zinc-fortified cereal or pureed meat well.
- Offer solid food 2 to 3 times per day; let him decide how much to eat.
- Avoid raw honey or large chunks of food that could cause choking.
- Consider introducing all other foods, including eggs and peanut butter, because research shows they may actually prevent individual food allergies.
- To prevent choking, give your baby only very soft, small bites of finger foods.
- Wash fruits and vegetables before serving.
- Introduce your baby to a cup with water, breast milk, or formula.
- Avoid feeding your baby too much; follow baby's signs of fullness, such as
 - Leaning back
 - Turning away
- Don't force your baby to eat or finish foods.
 - It may take 10 to 15 times of offering your baby a type of food to try before he likes it.

Helpful Resources: Smoking Quit Line: 800-784-8669 | Poison Help Line: 800-222-1222

Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

6 MONTH VISIT—PARENT



HEALTHY TEETH

- Ask us about the need for fluoride.
- Clean gums and teeth (as soon as you see the first tooth) 2 times per day with a soft cloth or soft toothbrush and a small smear of fluoride toothpaste (no more than a grain of rice).
- Don't give your baby a bottle in the crib. Never prop the bottle.
- Don't use foods or juices that your baby sucks out of a pouch.
- Don't share spoons or clean the pacifier in your mouth.

WHAT TO EXPECT AT YOUR BABY'S 9 MONTH VISIT

We will talk about

- Caring for your baby, your family, and yourself
- Teaching and playing with your baby
- Disciplining your baby
- Introducing new foods and establishing a routine
- Keeping your baby safe at home and in the car



SAFETY

- Use a rear-facing-only car safety seat in the back seat of all vehicles.
- Never put your baby in the front seat of a vehicle that has a passenger airbag.
- If your baby has reached the maximum height/weight allowed with your rear-facing-only car seat, you can use an approved convertible or 3-in-1 seat in the rear-facing position.
- Put your baby to sleep on her back.
- Choose crib with slats no more than 2 3/8 inches apart.
 - Lower the crib mattress all the way.
- Don't use a drop-side crib.
- Don't put soft objects and loose bedding such as blankets, pillows, bumper pads, and toys in the crib.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Do a home safety check (stair gates, barriers around space heaters, and covered electrical outlets).
- Don't leave your baby alone in the tub, near water, or in high places such as changing tables, beds, and sofas.
- Keep poisons, medicines, and cleaning supplies locked and out of your baby's sight and reach.
- Put the Poison Help line number into all phones, including cell phones. Call us if you are worried your baby has swallowed something harmful.
- Keep your baby in a high chair or playpen while you are in the kitchen.
- Do not use a baby walker.
- Keep small objects, cords, and latex balloons away from your baby.
- Keep your baby out of the sun. When you do go out, put a hat on your baby and apply sunscreen with SPF of 15 or higher on her exposed skin.

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.

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Basic Principles

1. Introduce around six months when the baby is sitting fairly steady and has lost the tongue thrust reflex. Formula and breastmilk should still be your baby's primary source of nutrition until twelve months. If possible, it is best to offer the breast milk/formula 30-60min before a solid meal.
2. Try to sit and eat with the baby at mealtimes, especially with baby-led weaning.
3. There is no need to start with rice cereal or oatmeal; start with any age-appropriate food you want. Be mindful of a healthy variety; even less healthy foods (pizza, desserts, etc.) are okay in moderation. There is no need to space out foods; several new foods are OK to be given in a day. Spices are OK, but salt should be limited and given in moderation. Avoid honey before age one. Avoid nuts, seeds, and popcorn until age three to five.
4. Offer plenty of iron-rich foods.
5. Introduce high-allergen foods sooner rather than later to lower the risk of allergy development (fish, shellfish, eggs, peanuts, wheat, dairy, sesame, nuts). Nuts can be given in butter or powdered form.
6. You can offer a sippy cup containing 1-2oz of water once or twice daily. Juice is not recommended unless it is indicated for constipation.
7. Slowly work up to three meals and 1-2 snacks by twelve months.

Purees:

1. Offer about one tablespoon of each food you are giving. Spoon feed and follow cues to stop when baby is all done (turning head, crying, pushing the spoon away).
2. As the pincer grasp develops around nine months, you should offer bite-sized pieces that the baby can pick up and eat.

Baby-led weaning (baby should be sitting well on his/her own):

1. We recommend reading Gill Rapley's Baby-Led Weaning or looking into Solid Starts or Feeding Littles. Feeding Littles has a great course!
2. Foods should be offered in finger-length shapes so baby can easily grasp the foods.
3. If foods are naturally pureed (applesauce, yogurt, etc), you can offer them on a preloaded spoon for the baby to feed on their own.
4. If foods are naturally smaller than finger-length, they are still okay to give; however, it might be more challenging for the baby to get them in his or her mouth.
5. Avoid anything coin-shaped (smush or halve blueberries and cut cherry tomatoes, cherries, grapes, hotdogs/sausage, and carrots lengthwise into quarters)
6. You can cut food into bite-sized pieces once the baby develops a pincer grasp.