NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: ☐MALE ☐FEMALE	PHONE:
DATE OF SERVICE:	INFORMANT:

9 MONTH CHECKUP — CHILD HEALTH RECORD

HISTORY

☐See new patient history form

INTERVAL HISTORY:
☐NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues, including Post-partum Depression Screening (use of validated tool required): ☐EPDS ☐PPDS ☐PHQ-9 ☐Other P ☐F ☐
Findings:

DEVELOPMENTAL/MENTAL HEALTH SCREENING:
Use of standardized tool: ☐ASQ ☐PEDS ☐SWYC P ☐F ☐
Findings:

NUTRITION*:
☐Breastmilk
Min per feeding: ____ Number of feedings in last 24 hrs: ____
☐Formula (type) _____
Oz per feeding: ____ Number of feedings in last 24 hrs: ____
Water source: _____ Fluoride: Y ☐ N ☐
☐Solids _____
See Bright Futures Nutrition Book if needed

IMMUNIZATIONS

☐Up to date ☐Deferred
Reason (if deferred):

Given today: ☐DTaP ☐Hep B ☐Hib ☐IPV
☐PCV ☐Meningococcal* ☐Hib-Hep B
☐DTaP-IPV-Hep B ☐DTaP-IPV/Hib ☐Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

☐See growth graph

Weight: _____ (_____%) Length: _____ (_____%)
Head Circumference: _____ (_____%)
Heart Rate: _____ Respiratory Rate: _____
Temperature (optional): _____

☐Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐Appearance	☐Mouth/throat	☐Genitalia
☐Head/fontanels	☐Teeth	☐Extremities
☐Skin	☐Neck	☐Back
☐Eyes	☐Heart/pulses	☐Musculoskeletal
☐Ears	☐Lungs	☐Hips
☐Nose	☐Abdomen	☐Neurological

Abnormal findings:

SENSORY SCREENING:
Subjective Vision Screening: P ☐ F ☐
Subjective Hearing Screening: P ☐ F ☐

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐Selected health topics addressed in any of the following areas*:

- Family Interaction
- Nutrition/Feeding Routine
- Safety
- Infant Development/Behavior

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office: _____

Signature/title

Signature/title

CHILD HEALTH RECORD

9 MONTH CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

9 Month Checkup

- Lead risk assessment*
- Establish consistent bedtime routine
- Maintain consistent family routine
- Make 1:1 time for each child in family
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Provide nap time daily
- Read books and talk about pictures/story using simple words
- Separation anxiety common
- Use distraction or choice of 2 appropriate options for discipline
- Introduce cup and encourage use to begin weaning process
- No bottle in bed
- Slowly increase choice of solids
- Cut table foods small, no hot dogs cut into circles
- Do not leave alone in bath water
- Empty all buckets containing water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach, remove all buckets
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Remove small toys/pins/plastic pieces to allow safe exploration
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

Ages 6 to 9 months

Yes	No	
☐	☐	Turns and looks to you when you are speaking in a quiet voice
☐	☐	Waves when you say “bye-bye”
☐	☐	Stops for a moment when you say “no-no”
☐	☐	Looks at objects or pictures when someone talks about them
☐	☐	Babbles song-like tunes
☐	☐	Uses voice to get your attention instead of crying
☐	☐	Uses different sounds and appears to be naming things

*LEAD RISK FACTORS

Perform a blood lead test if parent/caretaker answers “Yes/Don’t Know” to any of the questions below.	**Yes**	**Don’t know**	**No**
• Child lives in or visits a home, day care, or other building built before 1978 or undergoing repair	☐	☐	☐
• Pica (eats non-food items)	☐	☐	☐
• Family member with an elevated blood lead level	☐	☐	☐
• Child is a newly arrived refugee or foreign adoptee	☐	☐	☐
• Exposure to an adult with hobbies or jobs that may have risk of lead contamination (see Pb-110 for a list)	☐	☐	☐
• Food sources (including candy) or remedies (see Pb-110 for a list)	☐	☐	☐
• Imported or glazed pottery	☐	☐	☐
• Cosmetics that may contain lead (see Pb-110 for a list)	☐	☐	☐

The use of Form Pb-110 (Lead Risk Questionnaire) is optional. It is available at www.dshs.texas.gov/thsteps/forms.shtm.

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI Physician Referral and Orders for Early Childhood Intervention (ECI) form is available at:

https://hhs.texas.gov/services/disability/early-childhood-intervention-services/eci-information-health-medical-professionals