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

Texas Health Steps

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: Y ○ N ○
Findings:

DEVELOPMENTAL SCREENING:

Use of standardized tool: ○ ASQ ○ PEDS 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:

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:

Signature/title

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:

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

9 MONTH CHECKUP CHILD HEALTH RECORD

Texas Health Steps

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)

	Yes	No	
Ages 6 to 9 months	○	○	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 the Form Pb-110, Lead Risk Questionnaire is optional. It is available at www.dshs.texas.gov/thsteps/forms.shtm. If completed, return the form to the Texas Childhood Lead Poisoning Prevention Program as directed on the form.

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI referral form is available at:
http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf