

## Well-Visit Questionnaire Children Age 9 Months

## Your child is 9 months old!

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
☐ Well Visit ☐ Belly button ☐ Breathing ☐ Constipation ☐ Cough ☐ Development ☐ Diaper Rash	
☐ Eye discharge ☐ Feeding ☐ Fever ☐ Fussiness/crying ☐ Genitals ☐ Growth/nutrition	
☐ Head shape ☐ Nasal congestion ☐ Rash ☐ Stool change ☐ Vaccines ☐ Vomiting	
Other (please explain):	
Briefly describe your concern:	
Health Changes	
Has your child received any specialty or emergency care since the last visit?  If Yes, please describe:	Yes No
Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe:	Yes No
Nutrition, Feeding and Supplements – Tell us about what your child eats.	
My child eats (check all that apply):  Breastmilk Formula Cow's milk Solid food, like purees or soft finger foods	
My child drinks something other than milk/formula or water in their bottle:  If yes, what else do they drink in the bottle?	Yes No
My child eats iron-rich foods, like pureed meat, beans, iron-fortified cereal:	Yes No
My child receives daily Vitamin D:	Yes No
Please list any other vitamins, supplements, or over-the-counter medicines you give your child:	
Dental Health	
Do you clean your child's teeth every day?	Yes No
Does your water source have fluoride?	Yes No
Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.	
My child:	
Responds to their name:	Yes No
Babbles with repeated sounds, like ba-ba, da-da, ga-ga:	Yes No
Repeats sounds that I make:	Yes No
Sits steadily for several minutes without support:	Yes No



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Pulls up to stand while holding onto something (fingers, furniture):	Yes No
Picks up small objects between their thumb and pointer finger:	Yes No
Vision	
My child's eyes track together and almost never cross:	☐ Yes ☐ No
My child's eyes are the same color (both eyes and within each eye):	Yes No
Sleep	
My child:	
Sleeps in a (choose all that apply):	
☐ Crib or bassinet ☐ Shared bed ☐ Other product - please describe:	
Has a nap schedule and sleep routine:	Yes No
Is usually easy to put to sleep:	Yes No
Sleeps for long stretches at night:	Yes No
Safety	
My child rides in a rear-facing car seat in the back seat of the car for every car ride:	Yes No
We have gates across stairs and safety guards on windows:	Yes No
We have cleaning supplies, medicines, and matches locked away:	Yes No
My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets):	Yes No
Our water heater is set at 120 degrees or lower:	Yes No
Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	☐ Yes ☐ No
What is your plan for childcare?	
☐ Home with parent ☐ Family member ☐ Nanny or Sitter ☐ Childcare center	
Do you need assistance finding affordable and safe childcare?	Yes No
Is there anyone who lives in your home or cares for your child who:	
- Smokes or vapes tobacco or marijuana:	Yes No
- Uses prescription pain medication:	Yes No
- Uses other drugs:	Yes No
- Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	Yes No
Within the past 12 months, have you:	
- Run out of food or been worried your food would run out before there was money to buy more?	Yes No
- Worried about housing or had to move?	Yes No
- Had difficulty getting other supplies and services you need to care for your child?	Yes No
Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	I