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"?	○	○	○	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	___
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," "Peeka-boo," "clap your hands," "So Big")?	○	○	○	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	○	○	○	___
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.)*	○	○	○	___

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? 	○	○	○	___
2. When sitting on the floor, does your baby sit up straight for several minutes *without* using his hands for support? 	○	○	○	___

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GROSS MOTOR *(continued)*

		YES	SOMETIMES	NOT YET	
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? 	○	○	○	___
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? 	○	○	○	___
5.	While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	○	○	○	___
6.	Does your baby walk beside furniture while holding on with only one hand?	○	○	○	___

GROSS MOTOR TOTAL ___

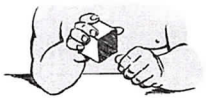
FINE MOTOR

		YES	SOMETIMES	NOT YET	
1.	Does your baby pick up a small toy with only one hand? 	○	○	○	___
2.	Does your baby ***successfully*** pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? *(If she already picks up a crumb or Cheerio, mark "yes" for this item.)* 	○	○	○	___
3.	Does your baby pick up a small toy with the *tips* of his thumb and fingers? *(You should see a space between the toy and his palm.)* 	○	○	○	___
4.	After one or two tries, does your baby pick up a piece of string with her first finger and thumb? *(The string may be attached to a toy.)* 	○	○	○	___
5.	Does your baby pick up a crumb or Cheerio with the *tips* of his thumb and a finger? He may rest his arm or hand on the table while doing it. 	○	○	○	___ *
6.	Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	○	○	○	___

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? 	○	○	○	___
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	○	○	○	___
3. When holding a toy in his hand, does your baby bang it against another toy on the table? 	○	○	○	___
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	○	○	○	___
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)?	○	○	○	___
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? *(Be sure the toy is completely hidden.)*	○	○	○	___

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? 	○	○	○	___
2. Does your baby drink water, juice, or formula from a cup while you hold it?	○	○	○	___
3. Does your baby feed himself a cracker or a cookie?	○	○	○	___
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? *(If she already lets go of the toy into your hand, mark "yes" for this item.)*	○	○	○	___
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?	○	○	○	___
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	○	○	○	___

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

Baby Pediatric Symptom Checklist (9-17 months)

Patient Name: _____ DOB/FDN: _____ Date: _____
Name of person answering this form: _____ Relation to patient: _____
Nombre de la persona llenando esta forma: _____ Relación al paciente: _____

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child./ Algunas veces todos los niños lloran, gruñen o se quejan, tienen problemas al dormir o tienen problemas cuando llegan a lugares nuevos. Comparado a la mayoría de los niños/as de esta edad, usted diría que su niño hace estas cosas igual, un poco más o mucho más que otros niños de su misma edad?	Not at all/ Igual (0)	Some-what/ Un poco mas (1)	Very Much/ Mucho mas (2)
1. *Does your child have a hard time being with new people?* | ¿Su niño/a tiene dificultad al estar con personas desconocidas?			
2. *Does your child have a hard time in new places?* | ¿Su niño/a tiene dificultad al estar en lugares nuevos?			
3. *Does your child have a hard time with change?* | ¿Su niño/a tiene dificultad con los cambios?			
4. *Does your child mind being held by other people?* | ¿A su niño/a le molesta que lo carguen otras personas?			
		Total	/3
5. *Does your child cry a lot?* | ¿Su niño/a llora mucho?			
6. *Does your child have a hard time calming down?*| ¿Su niño/a tiene dificultad para calmarse?			
7. *Is your child fussy or irritable?* | ¿Su niño/a se enoja fácilmente o se irrita?			
8. *Is it hard to comfort your child?* | ¿Su niño/a es di fícil de consolar?			
		Total	/3
9. *Is it hard to keep your child on a schedule or routine?* ¿Es difícil mantener a su niño/a en un horario o una rutina establecida?			
10. *Is it hard to put your child to sleep?* | ¿Es difícil poner a su niño/a a dormir?			
11. *Is it hard to get enough sleep because of your child?* | ¿Es difícil para usted dormir lo suficiente debido a su niño/a?			
12. *Does your child have trouble staying asleep?* | ¿Su niño/a tiene dificultad para mantenerse dormido?			
		Total	/3
Reviewed by:			

Childhood Lead Assessment Questionnaire **Cuestionario de evaluación infantil de riesgo por el Plomo**	**YES Si**	**NO No**	**Un-sure No se**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? ¿Su hijo (a) es elegible paea inscribirse en Medicaid, Head Start, All kids o WIC?			
2. Does this child have a sibling with a blood level of 10mcg/dl or higher? ¿Su hijo(a) tiene un hermano(a) con nivel de plomo en la sangre de 10mcg/dl o mas alto?			
3. Does this child live in regularly visit a home built before 1978? ¿Su hijo(a) vive o visita regularmente una casa que ya haya sido construida antes de 1978?			
4. In the past year has this child been exposed to repairs, repainting, or renovation of a home built before 1978? ¿Desde el año pasado, ha sido expuesto su hijo/a a reparaciones, pintura o remodelaciones dela casa construida antes de 1978?			
5. Is this child a refugee or an adoptee from any foreign country? ¿Su hijo(a) ha sido exilado o ha sido adoptado de algun pais extranjero?			
6. Has this child ever been to Mexico, Central or South America, Asian Countries, or any country where exposure to lead from certain items could have occurred (cosmetics, home remedies, folk medicines, or glazed pottery)? ¿Su hijo(a) ha hido a los siguientes paises: Mexico, America Central, o del sur, Asia, China o India, o cualquier pais donde pudo haber estado expuesto a objetos que contienen plomo? (por ejemplo, cosmeticos , remedios caseros, medicinas tradicionales o ceramica vidriada?			
7. Does this child live with someone who has a job or a hobby that may involve lead (jewelry making, building renovation or repair, bridge construction, pluming, furniture refinishing, leaded glass, lead shots, bullets or lead fishing sinkers?) ¿Vive su hijo(a) con alguna persona que tenga un trabajo o un pasatiempo que incluya plomo (joyas , renovación o construción de puentes, plomeria, recabados de muebles o un trabajo con baterias o radiadores de automoviles , soladores de plomo, vidrio de plomo, balas			
8. At any time has this Child lived near a factory where lead is used? ¿En algun momento su hijo(a) ha vivido cerca de una fabrica donde se use plomo?			
9. Does this child reside in a high-risk zip code? (High-risk zip codes- LAKE: 60040, MCHENRY: 60034, All Chicago zip codes) ¿Su hijo(a) vive en un codigo postal de alto riesgo? (Codigo de alto riesgo LAKE- 60040, MCHENRY- 60034, Todos los codigos postal de Chicago)			

Patient Name: _____

TUBERCULOSIS SCREEN QUESTIONNNAIRE FORMULARIO DE EVALUACION DE RIESGO DE TB PEDIATRICO	YES SI	NO NO
1. Has your child been exposed to anyone with the confirmed or suspected TB? ¿Su hijo(a) ha sido expuesto(a) a alguien que tenga o sospeche que tenga tuberculosis?		
2. Has your child been exposed to any family member or close friend who has been in jail in the last five years? /¿A estado su hijo/a expuesto a algun miembro de la familia o a un amigo cercano que ha estado encarcelado los ultimos cinco años?		
3. Has your child recently emigrated from Asia, the Middle East, Africa or Latin America? ¿Su hijo(a) ha emigrado de Asia, Medio Oeste, Africa o Latino America?		
4. Has your child recently traveled to Asia, the Middle East, Africa or Latin America? ¿A viajado su hijo(a) recientemente a Asia, Medio Oeste, Africa o Latino America?		
5. Does your child have HIV or live in a home with someone who has HIV? Tiene su hijo(a) SIDA o vive con alguien que tenga SIDA?		
6. Has your child been exposed to anyone with HIV, homeless residents or nursing homes, teens or adults in jail, or migrant farm workers? / ¿A estado su hijo (a) expuesto a alguien con SIDA, residente desamparado, que viva en un asilo, adultos encarcelados o trabajadores imigrantes de granja?		
7. Have you (parent) emigrated with known TB status from Asia, the Middle East, Africa or Latin America; Do you travel to these areas or have contact in your home with people from these areas with known TB status? ¿A usted(s) (padres) emigrado con estado positivo de TB de Asia, Africa, Medio Oriente o Latino America? ¿Viaja usted a estas areas o tiene contacto en su casa con personas de estas areas con estado positivo de TB?		
8. Does your child live in an area that you know to have a high prevalence of TB? ¿Vive su hijo(a) en una area que usted sabe ques sea de alto predomino de tuberculosis?		
9. Does your child have diabetes, chronic renal failure, malnutrition, or a problem with the immune system that he/she was born with or acquired later in childhood? / ¿Tiene su hijo(a) diabetes, insuficiencia renal crónica, desnutrición o un problema con el sistema immunológico con el que nació o adquirió en la infancia?		
Reviewed by:		