Developmental Milestones Checklist *

Child's Name _____ **DOB** _____

2 - 4 Weeks

- ☐ Responds to sounds by startling, blinking, crying, quieting, or breathing
- ☐ Looks at face and follows with eyes
- ☐ Responds to parent's face and voice
- ☐ Moves arms, legs, and head
- ☐ On stomach, lifts head momentarily
- ☐ Flexed posture
- ☐ Can sleep for three or four hours at a time
- ☐ Can stay awake for one hour or longer
- ☐ When crying, can be consoled most of the time, by being spoken to or held

Date _____ Signature _____

2 Months

- ☐ Coos and vocalizes reciprocally
- ☐ Pays attention to voices, other sounds, sights
- ☐ Smiles responsively
- ☐ Shows pleasure with parents
- ☐ Lifts head, neck, and upper chest with support of forearms while on stomach
- ☐ Has some control in upright position

Date _____ Signature _____

4 Months

- ☐ Babbles and coos
- ☐ Smiles, laughs, and squeals
- ☐ On stomach, holds head erect and raises body on hands
- ☐ Rolls over from stomach to back
- ☐ Opens hands, holds own hands, grasps rattle
- ☐ Good head control
- ☐ Reaches for and bats objects
- ☐ Recognizes parent's voice and touch

Date _____ Signature _____

6 Months

- ☐ Babbles reciprocally
- ☐ Says "dada" or "baba"
- ☐ When pulled to sit, has no head lag
- ☐ Sits with support
- ☐ Stands when placed
- ☐ Grasps and mouths objects
- ☐ Shows differential recognition of parents
- ☐ Transfers cubes from hand to hand
- ☐ Rakes in small objects
- ☐ Self-comforts
- ☐ Smiles, laughs, squeals, imitates razzing noise
- ☐ Turns to sound
- ☐ May have first tooth

Date _____ Signature _____

9 Months

- ☐ Responds to own name
- ☐ Understands a few words
- ☐ Babbles
- ☐ Crawls, creeps, or scoots
- ☐ Sits unsupported
- ☐ Poles with fingers, shakes, bangs, throws, drops objects
- ☐ Plays peek-a-boo or pat-a-cake
- ☐ Feeds self with fingers
- ☐ May show anxiety with strangers

Date _____ Signature _____

Reference: Bright Futures

***Note: This resource is not a standardized, validated screening tool.**

Risk Assessment Questionnaire

Patient's Name _____ **DOB** ____/____/____

Assessment Date _____/_____/_____

Lead (ages 6 – 72 months): Mandatory questions	**Yes**	**No**	**Unsure**
Does the child live in or regularly visit a house/apartment built before 1950? This could include a daycare center, home of a baby sitter, or a relative.)			
Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?			
Does the child have a sibling or a playmate that has, or did have lead poisoning?			

Lead (ages 6 – 72 months):Optional questions	**Yes**	**No**	**Unsure**
Does child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?			
Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery, etc.)			
Have you ever been told that your child has low iron?			
Does your child live in or regularly visit a house(or daycare facility) built before 1960?			
Does your family use pottery ware or lead crystal for cooking, eating or drinking?			
Has child been seen eating paint chips, crayons, or soil/dirt?			
Is child given any home or folk remedies that may contain lead (may include moonshine Azarcon, Greta, Paylooah)?			
Does your home's plumbing have lead pipes or copper pipes with lead solder joints?			

Please note: Lead level laboratory tests are mandatory at 12 and 24 months.

Tuberculosis (Initiate @ one- year)	**Yes**	**No**	**Unsure**
Has child been in close contact with a person with infectious tuberculosis?			
Does child have HIV infection or considered at risk for HIV infection?			
Is child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?			
Is child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?			
Does child have a depressed immune system, either because of disease or treatment of disease?			
Does child live in an established "high risk for tuberculosis" community or area?			

Cholesterol (Initiate @ two- years)	**Yes**	**No**	**Unsure**
Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease below age 55?			
Is there a family history (parents and grandparents) of elevated blood cholesterol?			

CARIES RISK ASSESSMENT QUESTIONNAIRE FOR CHILDREN

If there are NO teeth present in the child's mouth answer "no" to questions A through C.

VISUAL EXAMINATION: YES/NO

A.	Child has: one un-restored cavity	Y	N
	more than one un-restored cavity	Y	N
B.	Child has poor oral hygiene; visible plaque, gingivitis (redness or bleeding gums)	Y	N
C.	Child has enamel hypoplasia (white, chalky spots on teeth)	Y	N

HISTORY: YES /NO

A.	Mother or sibling has un-restored cavities	Y	N
B.	Lack of adequate fluoride exposure (family's drinking water source is a private well or the family's drinking water source is a public water supply that is not fluoridated and/or the child is not receiving fluoride supplements including fluoride contained in toothpaste)	Y	N
C.	Frequent (3 or more) between-meal exposures to snacks or foods containing simple sugars strongly associated with tooth decay such as carbonated beverages, juices, cookies, cakes, candy, French fries, potato chips, pretzels (If infant or child is nursed with a bottle, does the caretaker allow the infant or child to sleep or nap with a bottle containing juice, milk, or carbonated beverages)	Y	N
D.	Low socioeconomic status of parents ($\leq$100% Federal Poverty Level)	Y	N
E.	Family does not have a Dental Home or seldom visits a dentist	Y	N
F.	Child has special health care needs because of a chronic physical, developmental, behavioral, or emotional condition	Y	N
G.	Child has condition(s) that impairs saliva flow (congenital or acquired: surgery, radiation, medication, or age-related changes in salivary function)	Y	N

SCORE (total number of ***yes*** answers): _____

This questionnaire is designed to help identify children at High Risk for dental decay. **If the total number of *"Yes"* answers is $\geq$ 5, the child is at High Risk and should be referred to a dentist for an oral evaluation and the establishment of a Dental Home.** A ***Dental Home*** is an ongoing relationship between a patient and a dentist where comprehensive dentistry is continuously accessible in a family-centered way.

Approved by TDAC September 2009

EPDS

Name: _____

Date: _____ Baby's Age: _____

As you have recently had a baby, we would like to know how you are feeling. Please mark 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.

I have felt happy:

- ☐ Yes, all the time
- ■ Yes, most of the time
- ☐ No, not very often
- ☐ Not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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1. I have been able to laugh and see the funny side of things.

- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all _____

2. I have looked forward with enjoyment to things.

- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all _____

3. * I have blamed myself unnecessarily when things went wrong.

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very often
- ☐ No, never _____

4. I have been anxious or worried for no good reason.

- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, sometimes
- ☐ Yes, very often _____

5. * I have felt scared or panicky for not very good reason.

- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all _____

6. * Things have been getting on top of me.

- ☐ Yes, most of the time I haven't been able to cope at all
- ☐ Yes, sometimes I haven't been coping as well as usual
- ☐ No, most of the time I have coped quite well
- ☐ No, I have been coping as well as ever _____

7. * I have been so unhappy that I have had difficulty sleeping.

- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all _____

8. * I have felt sad or miserable.

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all _____

9. * I have been so unhappy that I have been crying.

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never _____

10.* The thought of harming myself has occurred to me.

- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never _____

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
J. L. Cox, J.M. Holden, R. Sagovsky
From: *British Journal of Psychiatry* (1987), 150, 782-786.

6/11/08