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?			

PATIENT NAME: _____ DOB: _____ DATE OF SERVICE: _____

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 (≤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 ≥ 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

ASQ-3 Ages & Stages Questionnaires®

9 months 0 days through 9 months 30 days

9 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to baby: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101090101

ASQ-3™ 9 Month Questionnaire

9 months 0 days through 9 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

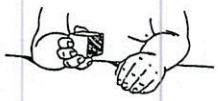
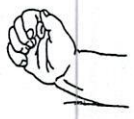
	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing? 	○	○	○	___
2. When sitting on the floor, does your baby sit up straight for several minutes *without* using his hands for support? 	○	○	○	___

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 ___

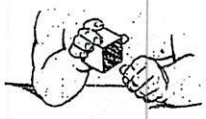
FINE MOTOR

		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 ___