

CHP Health Center for children ages 9 through 14 months

Please read each question carefully and

1. Check the box that best describes your child's behavior *and*

2. Check the circle 0 if this behavior is a concern

MOST
OF
TIME

SOMETIMES

RARELY
OR
NEVER

CHECK IF
THIS IS A
CONCERN

1. Does your baby laugh or smile at you and other family members?

z

v

x

0

2. Does your baby look for you when a stranger approaches?

z

v

x

0

3. Does your baby like to play near and be with family members and friends?

z

v

x

0

4. Does your baby like to be picked up and held?

z

v

x

0

5. When upset, can your baby calm down within a half hour?

z

v

x

0

6. Does your baby stiffen and arch her back when picked up?

x

v

z

0

7. Does your baby like to play games like Peekaboo?

z

v

x

0

8. Is your baby's body relaxed?

z

v

x

0

9. Does your baby cry, scream, or have tantrums for long periods of time?

x

v

z

0

Name _____

DOB _____

MR# _____

TOTAL POINTS ON PAGE _____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS CONCERN
10. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
11. Is your baby interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
12. Does it take longer than 30 minutes to feed your baby?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
13. Do you and your baby enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
14. Does your baby have any eating problems, such as gagging, vomiting, or _____? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
15. Does your baby have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
16. Does your baby make babbling sounds? For example, does he put sounds together, like "ba-ba-ba-ba" or "na-na-na-na"? (If your child often babbles, mark "most of the time.")	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
17. Does your baby sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	C
TOTAL POINTS ON				—

MOST OF THE TIME RARELY OR NEVER CHECK IF THIS IS A CONCERN

18. Does your baby get constipated or have diarrhea? x v z 0

19. Does your baby let you know when she is hungry, hurt, or tired? z v x C

20. When you talk to your baby, does he turn his head, look, or smile? z v x 0

21. Does your baby try to hurt other children, adults, or animals (for example, by kicking or biting)? x v z 0

22. Has anyone expressed concerns about your baby's behaviors? If you checked "sometimes" or "most of the time," please explain: x v z 0

23. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain:

Name _____ DOB _____ MR# _____ TOTAL POINTS ON PAGE _____

24. Is there anything that worries you about your baby? If so, please explain:

25. What things do you enjoy most about your baby?

Person filling out form _____
Relationship to child _____