Patient intake for 9 MONTH HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Visit related to any injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:
Verbal Sign language Written Assistive Communication Device

Preferred method of learning:
Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:
No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.
If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

Do you suspect your baby is in pain? ◆ **Staff- Evaluate pain with FLACC Tool***	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____	(◆ **Staff Request Records*)**	

Review of Symptoms (Place an "X" in all categories that apply):

Poor weight gain		Fever		Cough	
Hearing concerns		Headache		Wheezing	
Vision concerns		Sinus Congestion Present		Vomiting	
Difficulty Breathing		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in bowel habits		Pulling on Ears		Decreased Appetite	
Sweating with feeds		Ear Drainage		Other:	
Rash		Sore Throat			

Family Screening

Are any members of the household currently deployed or on extended duty outside of the immediate area?	**YES**	**NO**
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	**YES**	**NO**

Nutrition

Feeding Method?

Breast Bottle Spoon Cup Other_____

Feeding Type?

Breastmilk Formula Solids

Receiving Vitamin-D supplement daily?

Yes No

Oral Health Screening

In what county does your child live? _____

Do you have any concerns about your child's oral health? YES NO

♦ Lead Screen

- What is your child's primary address?_____
- Has a sibling or playmate had lead poisoning? Yes. No. Don't Know.
- Does your child reside in or visit a house or childcare facility built before 1978 which has peeling or chipping paint or has been renovated or remodeled within the last 6 months? Yes. No. Don't Know.
- Does your child come in contact with an adult whose job or hobby involves lead exposure (firing range, metal work, mining, stained glass work, renovation/remodeling)? Yes. No. Don't Know.
- Does your child ive in a household eligible for Medicaid, WIC, CHIP, or a state benefits program? Yes. No. Don't Know.
- Is your child a newly arrived refugee, immigrant, or a foreign adoptee? Yes. No. Don't Know.

Corpsmen: check lead exposure risk zone based on address at: https://fortress.wa.gov/doh/wtnibl/WTNIBL/
NOTIFY PROVIDER DURING TURNOVER of any "Yes" or "Don't Know" answers for Lead Screen.

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	**YES**	**NO**

Family history/Surgeries. Check all that apply.

Family History	**Patient** Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
♦To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare?	YES	NO

Please turn the page and complete the Developmental Questionnaire. Once you are done, please keep your paperwork with you and wait to be called back.

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! *****

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 9 months

9 months, 0 days to 11 months, 31 days
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Holds up arms to be picked up	0	1	2
Gets into a sitting position by him or herself	0	1	2
Picks up food and eats it	0	1	2
Pulls up to standing	0	1	2
Plays games like "peek-a-boo" or "pat-a-cake"	0	1	2
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	0	1	2
Copies sounds that you make	0	1	2
Walks across a room without help	0	1	2
Follows directions - like "Come here" or "Give me the ball"	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

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.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Tufts Children's Hospital

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********** Please continue on the back **********

(Below for Office Staff)

Weight: _____kg

Length: _____cm

Head Circumference: _____cm

Heart Rate: _____ bpm

Lead Exposure Risk Zone: _____

Respiratory Rate: _____ breaths/min

O2 sat (if indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

9 Month Health Supervision

Your child's growth:
Weight:_____lb. Percentile:_____
Length: _____in. Percentile:_____
Head Circumference:_____cm. Percentile:_____

Create a MHS Genesis Patient Portal Account
1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process

Click on me to go to the "**HealthyChildren.org**" Website! An American Academy of Pediatrics (AAP) guide to your child's milestones, growth and development. Search by age.

Feeding
- Give 3 meals and 2-3 snacks each day.
- Start giving healthy table foods.
- It may take 10-15 times of giving your baby a food to try before they will like it.
- Avoid honey until 12 months of age.
- Encourage drinking water from a cup.

Your Changing Baby
- Follow a regular bed-time routine and schedule. Minimize interaction with baby at night during awakenings.
- Encourage active play by offering balls, blocks, and containers to play with.
- Avoid the use of computers, TV, or videos
- Sing, speak and read to your baby often.
- Show and tell your baby what you want them to do.
- Brush teeth at least once daily.

Safety
- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Keep hanging cords or strings away from your baby.
- Keep a hand on your baby when changing clothes or the diaper.
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- Never leave your baby alone near water.
- Do not use a baby walker.
- Place gates on stairs.
- Lock up poisons, medicines, and cleaning supplies. Call Poison Control at 1-800-222-1222 if you need them.

Immunizations
- None scheduled!

When to call the doctor?
- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: https://centercitypediatrics.com/wait-worry-panic/

Next health supervision appointment: 12 months of age.

Patient specific guidance:

_____

_____

_____