KAISER PERMANENTE®

Well-Visit Questionnaire
Children Age 9 Months

Your child is 9 months old!

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
☐ Well Visit ☐ Belly button ☐ Breathing ☐ Constipation ☐ Cough ☐ Development ☐ Diaper Rash ☐ Eye discharge ☐ Feeding ☐ Fever ☐ Fussiness/crying ☐ Genitals ☐ Growth/nutrition ☐ Head shape ☐ Nasal congestion ☐ Rash ☐ Stool change ☐ Vaccines ☐ Vomiting ☐ Other (please explain):_____ Briefly describe your concern:_____	
Health Changes	
Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____	☐ Yes ☐ No
Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____	☐ Yes ☐ No
Nutrition, Feeding and Supplements – Tell us about what your child eats.	
My child eats (check all that apply): ☐ Breastmilk ☐ Formula ☐ Cow's milk ☐ Solid food, like purees or soft finger foods	
My child drinks something other than milk/formula or water in their bottle: If yes, what else do they drink in the bottle? _____	☐ Yes ☐ No
My child eats iron-rich foods, like pureed meat, beans, iron-fortified cereal:	☐ Yes ☐ No
My child receives daily Vitamin D:	☐ Yes ☐ No
Please list any other vitamins, supplements, or over-the-counter medicines you give your child: _____	
Dental Health	
Do you clean your child's teeth every day?	☐ Yes ☐ No ☐ N/A (no teeth)
Does your water source have fluoride?	☐ Yes ☐ No ☐ I don't know
Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.	
My child:	
Responds to their name:	☐ Yes ☐ No
Babbles with repeated sounds, like ba-ba, da-da, ga-ga:	☐ Yes ☐ No
Repeats sounds that I make:	☐ Yes ☐ No
Sits steadily for several minutes without support:	☐ Yes ☐ No

 Continued on next page

KAISER PERMANENTE®

Well-Visit Questionnaire

Children Age 9 Months

Pulls up to stand while holding onto something (fingers, furniture):	☐ Yes ☐ No
Picks up small objects between their thumb and pointer finger:	☐ Yes ☐ No
Vision	
My child's eyes track together and almost never cross:	☐ Yes ☐ No
My child's eyes are the same color (both eyes and within each eye):	☐ Yes ☐ No
Sleep	
My child:	
Sleeps in a (choose all that apply): ☐ Crib or bassinet ☐ Shared bed ☐ Other product - please describe: _____	
Has a nap schedule and sleep routine:	☐ Yes ☐ No
Is usually easy to put to sleep:	☐ Yes ☐ No
Sleeps for long stretches at night:	☐ Yes ☐ No
Safety	
My child rides in a rear-facing car seat in the back seat of the car for every car ride:	☐ Yes ☐ No
We have gates across stairs and safety guards on windows:	☐ Yes ☐ No
We have cleaning supplies, medicines, and matches locked away:	☐ Yes ☐ No
My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets):	☐ Yes ☐ No
Our water heater is set at 120 degrees or lower:	☐ Yes ☐ No
Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	☐ Yes ☐ No
What is your plan for childcare? ☐ Home with parent ☐ Family member ☐ Nanny or Sitter ☐ Childcare center	
Do you need assistance finding affordable and safe childcare?	☐ Yes ☐ No
Is there anyone who lives in your home or cares for your child who:	
- Smokes or vapes tobacco or marijuana:	☐ Yes ☐ No
- Uses prescription pain medication:	☐ Yes ☐ No
- Uses other drugs:	☐ Yes ☐ No
- Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	☐ Yes ☐ No
Within the past 12 months, have you:	
- Run out of food or been worried your food would run out before there was money to buy more?	☐ Yes ☐ No
- Worried about housing or had to move?	☐ Yes ☐ No
- Had difficulty getting other supplies and services you need to care for your child? Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	☐ Yes ☐ No

NOT TO BE FILED IN THE MEDICAL RECORD

Rev. Date 2021013