FLINT
FAMILY HEALTHCARE
4 N. MAIN STREET
MAYSVILLE, GA 30558

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Well Checkup - Newborn to 9 Months

Patient Name:

_____DOB:_____Appt. Date: _____

Feeding: ☐ Breast Fed ☐ Bottle Fed ☐ Both	Average Time Between Feedings: ☐ 1 to 2 hours ☐ 3 to 4 hours ☐ 5 to 6 hours	
Feedings per day: (Please Write a number)_____	Formula currently used: Brand Name and Type _____	
Solid Foods: (Circle what your child eats currently.) ☐ Cereals - Oat ☐ Cereals - Rice ☐ Cereals - Wheat ☐ Jar Baby Food ☐ Purees	Water: ☐ Bottled water ☐ Filtered Water ☐ Spring water ☐ Tap water ☐ Well water	
Any concerns about food/feeding?		
Stools: ☐ Normal ☐ Abnormal ☐	Stools - Daily Frequency ☐ 2 or less per day ☐ 3 to 4 per day ☐ Greater than 4 per day	Stool Character/Appearance: ☐ Hard ☐ Loose ☐ Soft ☐ Watery
Urine Stream: ☐ Normal ☐ Abnormal. If so, why?	Sleep: ☐ Normal ☐ Abnormal. If so, why?	Crying: ☐ Normal ☐ Abnormal. If so, why?
Skin problems: ☐ Normal ☐ Abnormal. If so, why?	Health/Emotional Status of Guardian: ☐ Depressed ☐ Happy ☐ Very Tired	Any Parental Concerns:

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Developmental Tasks

Please circle *yes* or *no* in response to each of the categories below

Communication	Coos and vocalized Different cries for different needs Imitates sounds Laughs Responds to names Vocalizes “Mama” or “Dada”	Yes No Yes No Yes No Yes No Yes No Yes No	**Fine Motor**	Bangs objects together Bring hands together Finger feeds Holds objects in 2 hands Reaches for and grabs objects Transfers from hand to hand	Yes No Yes No Yes No Yes No Yes No Yes No
Gross Motor Skills	Bears bear weight on their legs Begins to roll Crawls Grabs a rattle or a similar object Hold head erect Lifts head when lying on stomach Pulls to stand Raise body on their hands with head up Rolls both ways Rolls over Stis up alone for a few seconds	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	**Sensory**	Follows objects Responds to sounds Responds to touch	Yes No Yes No Yes No
Social	Laughs Plays Peek - A - Boo Shows pleasure interacting with others Smiles at mirrors Stranger anxiety Turns toward sounds	Yes No Yes No Yes No Yes No Yes No Yes No	**Developmental Concerns:**		