2–6 Months

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit

Child lives with:

_____ Mother _____ Father _____ Stepparent _____ Grandparent

_____ Other

Total adults living in home: ____________________

Total children living in home: ____________________

Primary caretaker for this child: ____________________

Relationship: ____________________

Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: _____P _____ F

Type of Developmental Screen:

Standardized Parent Questionnaire: ____________________

Standardized Observational Screen: ____________________

Other: ____________________

Further assessment needed: _____Y _____ N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:

Does the system review note any problems or parent concerns: _____Y _____N

Explain:

Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Physical Examination

Hct/Hgb ______ Lead ____________

Temp ________ Pulse ____________ Resp ____________

FOC __________ Height ____________ Weight ____________

(%) ___________ (%) ______________ (%) ______________

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes (RR)	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine/hips
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				**Neurologic:**
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts	____	__	___	Primitive reflexes

Additional documentation:

Client Information

Name: ____________________

DOB: _______ / _______ / ______ Age: __________ Sex: __________

SSN/Record No.: ____________________

Race/Ethnicity: ____________________

Informant/Relationship: ____________________

Medical Home: ____________________

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____Y _____N

**If answered yes, further assessment needed.*

Breast-fed: Number of feedings in last 24 hours: ________________

Length of feedings: ________________ **WIC:** _____Y _____N

Formula-fed: Type: ____________________

Iron fortified: _____Y _____N

Ounces consumed in 24 hours: _______ Fluoride: _____Y _____N

Solid foods introduced at age:

Sensory

Vision Screen: _____Normal _____ Abnormal

Hearing Screen: _____Normal _____ Abnormal

Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention

____Car safety restraints
____Falls, Infant walker
____Burns
____Choking management
____Sleep position (SIDS)
____Passive smoking
____Pool/bath safety

Behavior

____Parent/infant interaction
____Sleeping
____Inappropriate expectations
____Daycare/babysitters

Health Promotion

____Immunizations
____Thermometer use, Tylenol
____Teething, wipe teeth
____When to call doctor
____Well-child care
____Family planning

Nutrition

____Breastfeeding
____No solids until 4 months
____Formula preparation
____Infant held (no bottle in bed)

Assessment

Plan

WIC: ____Referred ___ Refused _ ___N/A

Immunizations: Up to date To be given today ___ Deferred

Explain:

Lab:

Newborn Screening: Up to date ____ To be done today

Next appointment:

Date: ______________ Signature/Title: ____________________ Signature/Title ____________________

2–6 Months

If used for documentation:____________________________________
Patient's Name: ____
Date: ____

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Eyes: Eye discharge, deviation, excessive tearing

Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, number of wet diapers
Neuromuscular: Seizures, coordinated movements
Musculoskeletal: Fractures, range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

2 Months

Smiles responsively
Inspects surroundings
Vocalizes in play
Lifts head

4 Months

Looks for source of sound
Hands together
Vocalizes to show displeasure
Head steady in supported position

6 Months

Reaches for objects
Responds to own name
Vocal imitation, imitates speech sounds
Rolls over

Progress Notes

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