PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
9 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Child Development screening and Oral Health Risk Assessment are also part of this visit.** Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your baby's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your baby's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING BABY

Do you have specific concerns about your baby's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your baby is able to do.

- ☐ Use basic gestures, such as holding her arms out to be picked up or waving "bye-bye."
- ☐ Look for dropped objects.
- ☐ Play games such as peekaboo and pat-a-cake.
- ☐ Turn consistently when his name is called.
- ☐ Say, "Dada" or "Mama."
- ☐ Look around when you say things such as "Where's your bottle?" and "Where's your blanket?"
- ☐ Copy sounds that you make.
- ☐ Sit well without support.
- ☐ Pull herself to a standing position.
- ☐ Move easily between sitting and lying.
- ☐ Crawl on hands and knees.
- ☐ Pick up food and eat it.
- ☐ Pick up small objects with 3 fingers and a thumb.
- ☐ Let go of objects on purpose.
- ☐ Bang objects together.

PATIENT NAME: _____ DATE: _____

Please print.

9 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your baby hears?	O No	O Yes	O Unsure
Lead	Does your baby live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your baby's primary water source contain fluoride?	O Yes	O No	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure
	Do your baby's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your baby's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Do you always feel safe in your home?	O Yes	O No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	O No	O Yes
Have you developed routines or other ways to take care of yourself?	O Yes	O No

CARING FOR YOUR BABY

Do you have a regular bedtime routine for your baby?	O Yes	O No
Does she wake up during the night?	O No	O Yes
Is your baby learning new things?	O Yes	O No
Does your baby have ways to tell you what he wants and needs?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?	O No	O Yes
Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day? _____hours	O No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No

DISCIPLINE

Do you and your partner agree on how to handle your baby's behavior?		O Yes	O No
Do you limit the use of "No" to only the most important issues?		O Yes	O No
If you have other children, do you let them help with the baby as much as they can?	O NA	O Yes	O No

FEEDING YOUR BABY

Does your baby feed herself?		O Yes	O No
Does your baby drink from a cup?		O Yes	O No
Do you let your baby decide what and how much to eat?		O Yes	O No
Do you give your baby foods with different textures (such as pureed, blended, mashed, chopped, or lumps)?		O Yes	O No
If you are breastfeeding, are you planning on continuing?	O NA	O Yes	O No

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	O Yes	O No
Do you have any habits or reminders that prevent you from ever leaving your baby in the car?	O Yes	O No
Do you keep your baby away from the stove, fireplaces, and space heaters?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

9 MONTH VISIT

SAFETY (*CONTINUED*)

Car and Home Safety (*continued*)		
Do you keep cleaners and medicines locked up and out of your baby's sight and reach?	O Yes	O No
Do you always stay within arm's reach of your baby when she is in the bathtub?	O Yes	O No
Do you keep furniture away from windows and use operable window guards on second-floor and higher windows? (Operable means that, in case of an emergency, an adult can open the window.)	O Yes	O No
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O No
Gun Safety		
Does anyone in your home or the homes where your baby spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

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Parent/Guardian Name (print) Signature Date

PEDS Response Form

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

1. Please list any concerns about your child's learning, development, and behaviour.

2. Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

5. Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

6. Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

7. Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

9. Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

10. Please list any other concerns.

PEDS Score Form – Authorised Australian Version

Child's Name:_____ Date of Birth:_____ Date(s) of scoring:_____

Find appropriate column for the child's age. Place a tick in the appropriate box to show each concern on the PEDS Response Form. See Brief Scoring Guide for details on categorising concerns. Shaded boxes are significant predictors of difficulties. Non-shaded boxes are non significant predictors.

Child's Age:	0-3 mos	4-5 mos	6-11 mos	12-14 mos	15-17 mos	18-23 mos	24-35 mos	36-47 mos	48-53 mos	54-71 mos	72-83 mos	84-96 mos
Global/Cognitive	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Expressive Language and Articulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Receptive Language	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fine Motor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gross Motor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social-emotional	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-help	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
School	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Count the number of ticks in the small shaded boxes and place the total in the large shaded box below.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the number shown in the large shaded box is 2 or more, follow **Path A** on PEDS Interpretation Form. If the number shown is exactly 1, follow **Path B**. If the number shown is 0, count the number of ticks in the small unshaded boxes and place the total in the large unshaded box below.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the number shown in the large unshaded box is 1 or more, follow **Path C**. If the number 0 is shown, consider **Path D** if relevant. Otherwise, follow **Path E**.

Child's Name:_____ Date of Birth:_____

PEDS Interpretation Form

Path A: Two or more significant predictive concerns? → Yes? → Two or more concerns about self-help, social, school, or receptive language skills?
- Yes? → Refer for audiological and speech-language testing. Use professional judgment to decide if referrals are also needed for social work, occupational/physiotherapy, mental health services, etc.
- No? → Refer for intellectual and educational assessments. Use professional judgment to decide if speech-language, audiological, or other evaluations are also needed.

Path B: One significant predictive concern? → Yes? → Screen or refer for screening.
- If screen is passed, counsel in areas of concern and monitor carefully.
- If screen is failed, refer for testing in area(s) of difficulty.

Path C: Non significant concerns? → Yes? → Counsel in areas of difficulty and follow up in several weeks. → If unsuccessful, screen for emotional/behavioural problems and refer as indicated. Otherwise refer for parent training, behavioural intervention, etc.

Path D: Parental difficulties communicating? → Yes? → Foreign language a barrier?
- No? → Use a second screen that directly elicits children's skills or refer for screening elsewhere.
- Yes? → Send PEDS home in preparation for a second visit; seek an interpreter, or refer for screening elsewhere.

Path E: No concerns? → Yes? → Elicit any concerns at future time-point? → Use PEDS at future time-point.

Specific Decisions

0–3 mos. _____

4–5 mos. _____

6–11 mos. _____

12–14 mos. _____

15–17 mos. _____

18–23 mos. _____

24–35 mos. _____

36–47 mos. _____

48–53 mos. _____

54–71 mos. _____

72–83 mos. _____

84–96 mos. _____

PROVIDER ONLY