

CHILD HEALTH CLINIC ASSESSMENT

Name: _____

Surname

Given

Birthdate: _____

yyyy

mm

dd

Date/age	1 mos			2 mos			4 mos			6 mos		
	wt	ht	hc	wt	ht	hc	wt	ht	hc	wt	ht	hc
Parental concerns												
Family Adjustment												
Nutrition	<input type="checkbox"/> BF & vit D 200 iu <input type="checkbox"/> formula with Fe (150ml/kg/day) <input type="checkbox"/> no honey			<input type="checkbox"/> BF & vit D 200 iu <input type="checkbox"/> formula with Fe (150ml/kg/day) <input type="checkbox"/> no honey			<input type="checkbox"/> BF & vit D 200 iu <input type="checkbox"/> formula with Fe <input type="checkbox"/> Fe fortified cereal <input type="checkbox"/> can start solids <input type="checkbox"/> no honey			<input type="checkbox"/> BF or FF with Fe <input type="checkbox"/> intro textured foods <input type="checkbox"/> intro meat & alternatives <input type="checkbox"/> avoid salt & sugar <input type="checkbox"/> no honey		
Development	<input type="checkbox"/> focuses gaze <input type="checkbox"/> holds hands in fists <input type="checkbox"/> sucking & rooting reflex <input type="checkbox"/> lifts head momentarily when prone <input type="checkbox"/> tummy time			<input type="checkbox"/> posterior fontanel closed <input type="checkbox"/> raises head 45° when prone <input type="checkbox"/> smiles <input type="checkbox"/> tummy time			<input type="checkbox"/> head steady <input type="checkbox"/> grasps briefly <input type="checkbox"/> starts to roll <input type="checkbox"/> recognizes familiar objects <input type="checkbox"/> plays with hands			<input type="checkbox"/> roll back to tummy <input type="checkbox"/> starts to sit <input type="checkbox"/> legs can support own weight <input type="checkbox"/> tries to pick up Cheerio <input type="checkbox"/> puts toy in mouth		
Safety	<input type="checkbox"/> car seat <input type="checkbox"/> crib <input type="checkbox"/> sleep position <input type="checkbox"/> second-hand smoke <input type="checkbox"/> falls <input type="checkbox"/> smoke detector <input type="checkbox"/> burns			<input type="checkbox"/> falls <input type="checkbox"/> car seat <input type="checkbox"/> burns (microwave/hot liquids) <input type="checkbox"/> suffocation			<input type="checkbox"/> poisons (plants, chemicals) <input type="checkbox"/> electric plugs <input type="checkbox"/> falls <input type="checkbox"/> burns (liquids/surfaces) <input type="checkbox"/> choking (safe toys, food)			<input type="checkbox"/> poisons <input type="checkbox"/> burns (hot surfaces, liquids) <input type="checkbox"/> falls <input type="checkbox"/> electric outlets <input type="checkbox"/> choking (food, toys)		
Speech/Hearing	<input type="checkbox"/> startles or cries at noises <input type="checkbox"/> listens to voice <input type="checkbox"/> makes limited noises (mostly cries)			<input type="checkbox"/> laughs, goes <input type="checkbox"/> recognizes familiar voices			<input type="checkbox"/> turns eyes to sounds/voices <input type="checkbox"/> makes more "speech-like" sounds <input type="checkbox"/> non-speech sounds (raspberries, squeals, yelling, growling) <input type="checkbox"/> wakes easily to sound			<input type="checkbox"/> starts to play with sounds (vowels + consonants) <input type="checkbox"/> turns head to soft sounds		
Vision	<input type="checkbox"/> can see 20-25cm <input type="checkbox"/> tears start			<input type="checkbox"/> follows moving object with eyes			<input type="checkbox"/> eyes may cross or wander at times			<input type="checkbox"/> can follow object <input type="checkbox"/> eyes do not cross		
Dental/Mouthcare	<input type="checkbox"/> clean gums with damp cloth			<input type="checkbox"/> clean gums with damp cloth			<input type="checkbox"/> clean gums with damp cloth <input type="checkbox"/> begins drooling			<input type="checkbox"/> wipe teeth with fluoridated toothpaste <input type="checkbox"/> nursing bottle decay <input type="checkbox"/> if at risk, .25mg fluoride/day		
Immunization	<input type="checkbox"/> given <input type="checkbox"/> informed consent			<input type="checkbox"/> given <input type="checkbox"/> informed consent			<input type="checkbox"/> given <input type="checkbox"/> informed consent			<input type="checkbox"/> given <input type="checkbox"/> informed consent		
Signature												

Code blank=not assessed ✓=done O=observe R=referral

Date/age	8-9 mos			12 mos			18 mos			4-5 yrs		
Growth	wt	ht	hc	wt	ht	hc	wt	ht	hc	wt	ht	hc
Parental concerns												
Family Adjustment												
Nutrition	<input type="checkbox"/> BF or FF with Fe <input type="checkbox"/> food chunkier <input type="checkbox"/> finger food <input type="checkbox"/> cooked egg yolk <input type="checkbox"/> cup for drinking (e.g. diluted fruit juice) <input type="checkbox"/> no honey			<input type="checkbox"/> whole cow's milk <input type="checkbox"/> enjoy family meals <input type="checkbox"/> solids 5-6 a day <input type="checkbox"/> whole egg <input type="checkbox"/> avoid grapes, hot dog, peanuts, raw veg, popcorn			<input type="checkbox"/> water every day <input type="checkbox"/> 2-3 cups milk <input type="checkbox"/> choose food from Canada Food Guide <input type="checkbox"/> prevent choking <input type="checkbox"/> feeds self <input type="checkbox"/> feeding relationship			<input type="checkbox"/> 4 or more servings grain <input type="checkbox"/> 4 or more servings fruit & veg <input type="checkbox"/> 3-4 milk products <input type="checkbox"/> 2 meat or alt. <input type="checkbox"/> use fork & spoon		
Development	<input type="checkbox"/> sits upright <input type="checkbox"/> gets into crawling position <input type="checkbox"/> picks up Cheerio with finger & thumb <input type="checkbox"/> bangs toy on table <input type="checkbox"/> transfer toy <input type="checkbox"/> peek-a-boo			<input type="checkbox"/> walks along furniture <input type="checkbox"/> throws ball <input type="checkbox"/> puts toys in a container <input type="checkbox"/> hugs stuffed toy <input type="checkbox"/> shakes head "no" <input type="checkbox"/> scribble on paper			<input type="checkbox"/> walks well <input type="checkbox"/> climbs on objects <input type="checkbox"/> stacks 3 blocks <input type="checkbox"/> draws lines <input type="checkbox"/> copies activities, e.g. combs hair <input type="checkbox"/> ant. fontanel closed			<input type="checkbox"/> draws person 2-6 parts <input type="checkbox"/> stands on 1 foot x 5 seconds <input type="checkbox"/> dresses self <input type="checkbox"/> counts to 10 <input type="checkbox"/> cooperative play <input type="checkbox"/> limit TV		
Safety	<input type="checkbox"/> stairways (gates) <input type="checkbox"/> electrical outlets <input type="checkbox"/> bodily harm, e.g. corners of furniture			<input type="checkbox"/> car seat (forward facing at 10kg/20lbs) <input type="checkbox"/> drowning (bathtubs) <input type="checkbox"/> choking <input type="checkbox"/> falls (strollers) <input type="checkbox"/> poisons (plants, medications, chemicals)			<input type="checkbox"/> burns/fires <input type="checkbox"/> drowning (pools) <input type="checkbox"/> teach traffic safety <input type="checkbox"/> falls (crib/bed) <input type="checkbox"/> poisons <input type="checkbox"/> suffocation (cords on blinds? clothes?)			<input type="checkbox"/> move to booster at 20kg/40lbs) <input type="checkbox"/> drowning (pools) <input type="checkbox"/> traffic safety <input type="checkbox"/> bike helmet <input type="checkbox"/> falls (bunk bed, playground) <input type="checkbox"/> poisons (meds) <input type="checkbox"/> burns (sun)		
Speech/Hearing	<input type="checkbox"/> uses facial expression, eye gaze, vocalizing and pointing to communicate <input type="checkbox"/> babbles using repeated syllables (ba ba ba)			<input type="checkbox"/> babbling continues, now with different syllables (ba da na) <input type="checkbox"/> may start to say a few words			<input type="checkbox"/> vocabulary increases (50 words by 24 months) <input type="checkbox"/> follows simple instructions (get your socks)			<input type="checkbox"/> can carry on a conversation (asks & answers questions) <input type="checkbox"/> speaks in complete sentences <input type="checkbox"/> speech is generally easy to understand		
Vision							<input type="checkbox"/> recommend 3 yr. vision screening			<input type="checkbox"/> kindergarten vision screen		
Dental/Mouthcare	<input type="checkbox"/> nursing bottle decay <input type="checkbox"/> if at risk, .25mg fluoride/day			<input type="checkbox"/> use soft brush with smear of fluoridated toothpaste <input type="checkbox"/> if at risk, .25mg fluoride/day			<input type="checkbox"/> 20 teeth (between 18 mos to 2 yrs) <input type="checkbox"/> brush teeth x 2 a day <input type="checkbox"/> if at risk, .25mg fluoride/day			<input type="checkbox"/> child cleans teeth 2x a day & parents finish job <input type="checkbox"/> ? dental visits <input type="checkbox"/> no soothers <input type="checkbox"/> if at risk, .5mg fluoride/day		
Immunization	<input type="checkbox"/> given <input type="checkbox"/> informed consent			<input type="checkbox"/> given <input type="checkbox"/> informed consent			<input type="checkbox"/> given <input type="checkbox"/> informed consent			<input type="checkbox"/> given <input type="checkbox"/> informed consent		
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