# 1 Month Questionnaire

**Who lives in the household(ex. Mother, brother)?_____

1) List: any concerns you have for the pt. _____

_____

2) Are they breast-fed or formula?_____ if formula, what name ?_____how many ounces _____ hour (s)?
-if breast, how many min. per breast?_____ every _____hour(s).

3) Is she/he pooping and peeing okay? _____sleeping okay? _____fussy or good-natured?_____

4) Can he/she lift head about 90 degrees?_____ Hold head steady? _____

5) Can they follow with their eyes both ways, past the mid-line?_____

6) Does he/she like to cuddle?_____

7) Does he/she recognize faces?_____

8) Does he or she cry, without reason; sometimes whining for no reason?_____

9) Does he/she respond to sound ?_____vocalize (cry)well?_____
coo?_____ Squeal?_____

10) Does he/she smile (responsive or just out of the blue?_____

11) Can he/she regard their own hand? _____face?_____(This means putting hand in their mouth or touching their face.

12) Can he/she roll over?_____

13) Can he/she bear weight on their legs?_____

14) Can he/she pull to sit(head comes up with them)?_____

15) Can he/she put hands together?_____

16) Is he/she allergic to any medications?_____

17) Is he/she taking any medications?_____-

18) Does anyone smoke around him/her?_____

19) Any pets in the home?_____

20) Any excessive sun exposure_____

21) Any Guns in the home_____

22) Is your home Child proofed_____

23) Any problems since last visit _____

24) Any developmental concerns _____

25) Is the child still using a car seat_____

Thanks for completing this form! ☺