



# SWYC:<sup>TM</sup> 9 months

9 months, 0 days to 11 months, 31 days  
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

## DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Holds up arms to be picked up . . . . .	0	1	2
Gets into a sitting position by him or herself . . . . .	0	1	2
Picks up food and eats it . . . . .	0	1	2
Pulls up to standing . . . . .	0	1	2
Plays games like "peek-a-boo" or "pat-a-cake" . . . . .	0	1	2
Calls you "mama" or "dada" or similar name . . . . .	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?" . . . . .	0	1	2
Copies sounds that you make . . . . .	0	1	2
Walks across a room without help . . . . .	0	1	2
Follows directions - like "Come here" or "Give me the ball" . . . . .	0	1	2

## BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people? . . . . .	0	1	2
Does your child have a hard time in new places? . . . . .	0	1	2
Does your child have a hard time with change? . . . . .	0	1	2
Does your child mind being held by other people? . . . . .	0	1	2
Does your child cry a lot? . . . . .	0	1	2
Does your child have a hard time calming down? . . . . .	0	1	2
Is your child fussy or irritable? . . . . .	0	1	2
Is it hard to comfort your child? . . . . .	0	1	2
Is it hard to keep your child on a schedule or routine? . . . . .	0	1	2
Is it hard to put your child to sleep? . . . . .	0	1	2
Is it hard to get enough sleep because of your child? . . . . .	0	1	2
Does your child have trouble staying asleep? . . . . .	0	1	2

**PARENT'S CONCERNS**

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have any concerns about your child's behavior?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**FAMILY QUESTIONS**

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	<input type="radio"/> Y	<input type="radio"/> N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	<input type="radio"/> Y	<input type="radio"/> N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	<input type="radio"/> Y	<input type="radio"/> N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	<input type="radio"/> Y	<input type="radio"/> N

  

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

  

<i>Over the past two weeks, how often have you been bothered by any of the following problems?</i>	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7 Feeling down, depressed, or hopeless?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

  

	No tension	Some tension	A lot of tension	Not applicable
8 In general, how would you describe your relationship with your spouse/partner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

  

	No difficulty	Some difficulty	Great difficulty	Not applicable
9 Do you and your partner work out arguments with:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

  

10 During the past week, how many days did you or other family members read to your child?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
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# blackmon



pediatrics

Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? \_\_\_\_\_

**Can you describe your child's nutritional habits?**

- |                                  |            |          |                              |                |              |
|----------------------------------|------------|----------|------------------------------|----------------|--------------|
| 1. Feeding:                      | Breast     | Formula  | Milk                         | Specify Brand: | _____        |
| 2. Feeding Problems:             |            | Yes      | No                           | Specify:       | _____        |
| 3. Taking multivitamin with iron |            | Yes      | No                           |                |              |
| 4. Number of diapers per day:    | Wet _____  |          | Strong urine stream (males): | Yes            | No           |
| 5. Water Source:                 | City _____ |          | Well                         |                | Stool _____  |
| 6. Taking solids:                | Cereal     | Fruits   | Veggies                      |                | Bottle _____ |
| 7. Appetite:                     | Good       | Variable | Picky                        |                | Meats _____  |
| 8. Weaned from bottle/breast     | Yes        | No       |                              |                |              |

**Does your child have any problems with the following?**

- |                     |     |    |                |     |    |
|---------------------|-----|----|----------------|-----|----|
| 1. Spitting Up      | Yes | No | 4. Sleep       | Yes | No |
| 2. Excessive Crying | Yes | No | 5. Stuffy Nose | Yes | No |
| 3. Constipation     | Yes | No | 6. Diaper Rash | Yes | No |

**Do you have any concerns about your child's hearing or vision?**

Yes \_\_\_\_\_ No \_\_\_\_\_ Specify: \_\_\_\_\_

**Lead Screening (please answer for ages 6 months, 9 months, 12 months, and 18 months)**

- |   |     |    |
|---|-----|----|
| 1. Does your child live in or regularly visit a house built before 1950?                                      | Yes | No |
| 2. Does your child live in or regularly visit a house built before 1978 with recent renovations?              | Yes | No |
| 3. Does your child have a sibling or playmates that have or have had lead poisoning?                          | Yes | No |
| 4. Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking? | Yes | No |

Has there been any foreign travel in the last 60 days or international adoption? Yes \_\_\_\_\_ No \_\_\_\_\_

Has there been any exposure to smoking? Yes \_\_\_\_\_ No \_\_\_\_\_ Who: \_\_\_\_\_

**Immunizations**

- |   |     |    |
|---|-----|----|
| 1. Previous reaction to immunizations                     | Yes | No |
| 2. Have family members been immunized (mom, dad, sibling) | Yes | No |
| 3. History of chickenpox in child being seen              | Yes | No |
| 4. Serious illness at home or relatives (cancer)          | Yes | No |
| 5. Allergic to eggs, gelatin, Neomycin, yeast             | Yes | No |

**Please describe your social history.**

- |                      |                      |
|----------------------|----------------------|
| 1. Race: _____       | 4. Ethnicity: _____  |
| 2. Language: _____   | 5. # Siblings: _____ |
| 3. Lives With: _____ |                      |

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes \_\_\_\_\_ No \_\_\_\_\_ Specify: \_\_\_\_\_

**Have there been any changes in your child's medical needs?**

- |  |       |    |                |
|--|-------|----|----------------|
| 1. New problems or illness   | Yes   | No | Specify: _____ |
| 2. Please list current medications (prescription and over-the-counter) | _____ |    |                |

Well Check Questions (1 to 18 Months)

# THE HISTORY OF THE CITY OF BOSTON

The history of the city of Boston is a story of growth and resilience. From its founding as a small settlement of Puritan settlers, it has grown into a major center of commerce, industry, and culture. The city's location on a narrow neck of land between the harbor and the mainland has shaped its development, making it a natural port and a strategic military position. Over the centuries, Boston has been the site of numerous significant events, including the American Revolution, the abolitionist movement, and the rise of the Industrial Revolution. The city's rich history is reflected in its architecture, museums, and traditions, which continue to shape its identity today.

The city's history is a testament to the spirit of innovation and the pursuit of a better life. From the early days of settlement to the present, Boston has always been a place where ideas are born and where people strive for progress. The city's history is a story of triumph and adversity, of challenges overcome and dreams realized. It is a story that continues to inspire and inform us today.