

# New Jersey: Early and Periodic Screening, Diagnosis and Treatment Exam

## INFANCY: 6 MONTHS

DATE: \_\_\_\_\_

Child's Name: _____		Date of Birth: _____	
Allergies: _____		Current Medications: _____	
Illnesses/Accidents/Problems/Concerns since birth: _____			

  

<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<input type="checkbox"/> My baby eats some solid foods	<input type="checkbox"/> My baby can pick up objects		
<input type="checkbox"/> My baby says things like "da da" or "ba ba"	<input type="checkbox"/> My baby seems happy		
<input type="checkbox"/> My baby sits with help/support	<input type="checkbox"/> My baby recognizes me		
<input type="checkbox"/> I am concerned that I have frequent sadness			

  

WEIGHT KG/LB PERCENTILE: _____	HEIGHT CM/IN PERCENTILE: _____	HEAD CIR. PERCENTILE: _____	Diet: _____  <input type="checkbox"/> Vitamin Supplements <input type="checkbox"/> Newborn Hearing Screening Results <input type="checkbox"/> Review Immunization Record <input type="checkbox"/> Lead Risk Assessment (verbal) <input type="checkbox"/> WIC Referral  Elimination: _____ Sleep: _____ Other: _____
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<input type="checkbox"/> Review of Systems <input type="checkbox"/> Review of Family History  _____ _____ _____		<b>Health Education/Anticipatory Guidance:</b> <b>(CHECK ALL COMPLETED)</b> <input type="checkbox"/> Family Planning <input type="checkbox"/> Safety (general) <input type="checkbox"/> Infant Temperament <input type="checkbox"/> Development Benchmarks <input type="checkbox"/> Crib Safety <input type="checkbox"/> Shaken Baby Syndrome <input type="checkbox"/> No Bottle in Bed <input type="checkbox"/> Feeding <input type="checkbox"/> Fever Protocols <input type="checkbox"/> Teething <input type="checkbox"/> Bedtime Ritual <input type="checkbox"/> Language Stimulation <input type="checkbox"/> Stranger Anxiety <input type="checkbox"/> Appropriate Car Seat <input type="checkbox"/> Child Care Issues <input type="checkbox"/> Passive Smoke <input type="checkbox"/> Oral Health Care <input type="checkbox"/> Lead Poison Prevention  Other: _____
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<b>Screening</b>	<b>N</b>	<b>A</b>	Hearing <input type="checkbox"/> _____ Vision <input type="checkbox"/> _____ Development <input type="checkbox"/> _____ Behavior <input type="checkbox"/> _____ Social/Emotional <input type="checkbox"/> _____ Gross Motor <input type="checkbox"/> _____ Fine Motor <input type="checkbox"/> _____
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<b>Physical</b>	<b>N</b>	<b>A</b>	General Appearance <input type="checkbox"/> _____ Skin <input type="checkbox"/> _____ Head/Fontanelle <input type="checkbox"/> _____ Eyes <input type="checkbox"/> _____ Ears <input type="checkbox"/> _____ Nose <input type="checkbox"/> _____ Oropharynx/Teeth <input type="checkbox"/> _____ Dental Structure & Tongue <input type="checkbox"/> _____ Mental health <input type="checkbox"/> _____
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<b>Physical</b>	<b>N</b>	<b>A</b>	Lungs <input type="checkbox"/> _____ Chest <input type="checkbox"/> _____ Cardiovascular/Pulses <input type="checkbox"/> _____ Abdomen <input type="checkbox"/> _____ Genitalia <input type="checkbox"/> _____ Spine <input type="checkbox"/> _____ Extremities <input type="checkbox"/> _____ Neurological <input type="checkbox"/> _____
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<b>Describe findings:</b> _____ _____ _____ _____ _____ _____ _____	<b>Assessment:</b> _____ _____ _____ <b>Diagnosis:</b> _____ <b>Treatment Plan:</b> _____ _____ _____ <b>REFERRALS:</b> _____ _____ _____ <b>IMMUNIZATIONS:</b> <input type="checkbox"/> given (see VFC Form) <input type="checkbox"/> up to date
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**NEXT VISIT: 9 MONTHS OF AGE**

Health Provider Signature: \_\_\_\_\_