6 Month
Well Check Questionnaire

Please answer these questions about your child.
Skip any questions that you cannot answer or that do not apply.
Your answers will help us provide you and your child with the best possible care.

Do you have any questions or concerns that you would like to discuss with your doctor? . . . . . ☐ **Yes** ☐ **No**
If yes, please describe: _____

NUTRITION

1. What does your child eat? ☐ **Only breast milk** ☐ **Some breast milk, some formula** ☐ **Only formula**
2. Do you offer solid foods? . . . . . ☐ **No** ☐ **Yes**

If your child is breastfeeding: *[If your child is **not** breastfeeding, please skip to* **DENTAL HEALTH***.]*

3. Do you give your child vitamin D drops? . . . . . ☐ **No** ☐ **Yes**

DENTAL HEALTH

4. Do you give your child a bottle with anything in it except breast milk, formula, or water? . . . . . ☐ **Yes** ☐ **No**
5. Do you ever put your child in his or her crib with a bottle? . . . . . ☐ **Yes** ☐ **No**

SAFETY

6. Do you place your child in a rear-facing car seat in the backseat for every car ride? . . . . . ☐ **No** ☐ **Yes**
7. Does your home keep cleaning supplies, medicines, and matches locked away? . . . . . ☐ **No** ☐ **Yes**
8. Do you have the phone number of the Poison Control Center (800-222-1222) posted by your telephone and/or saved in your cell phone? . . . . . ☐ **No** ☐ **Yes**

YOUR GROWING CHILD

9. Do you have any concerns about your child's weight? . . . . . ☐ **Yes** ☐ **No**
10. Does your child make sounds like "ga," "ma," or "ba"? . . . . ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**
11. Does your child roll over? . . . . . ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**
12. Does your child pass a toy from one hand to the other? . . ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**
13. Does your child hold 2 objects and bang them together? ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**

FAMILY LIFE

14. Does your child watch TV or videos? . . . . . ☐ **Yes** ☐ **No**
15. Is your child ever left alone, such as in the house or car? . . . . . ☐ **Yes** ☐ **No**
16. Since your child's last checkup, has your family or child experienced any major issues (such as illness, move, job change or loss, separation or divorce, or death in the family)? . . . . . ☐ **Yes** ☐ **No**
    If yes, please list: _____

For mother of child:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

17. Little interest or pleasure in doing things?
    ☐ **Not at all** ☐ **Several days** ☐ **More than half the days** ☐ **Nearly every day**
18. Feeling down, depressed, or hopeless?
    ☐ **Not at all** ☐ **Several days** ☐ **More than half the days** ☐ **Nearly every day**

00244-041 (Revised 8/15)

KAISER PERMANENTE®

6個月
健康核查問卷

請回答以下有關您孩子的問題。
請跳過任何您無法回答或不適用的問題。
您的回答將幫助我們為您和孩子提供最佳護理。

您有任何疑問或顧慮想要咨詢醫生嗎？ ☐ 是 ☐ 否
如果回答「是」，請說明：_____

營養

1. 您給孩子吃什麼？ ☐ 僅母乳 ☐ 部分母乳，部分奶粉 ☐ 僅奶粉
2. 您給孩子餵食固體食物嗎？ ☐ 否 ☐ 是

如果您的孩子喝母乳： *[如果您的孩子現在**不**喝母乳，請直接跳至「**牙齒健康**」。]*

3. 您給孩子服用維生素D滴劑嗎？ ☐ 否 ☐ 是

牙齒健康

4. 除裝有母乳、沖泡奶粉或水的奶瓶外，您還會給孩子裝有其他東西的奶瓶嗎？ ☐ 是 ☐ 否
5. 您是否曾將孩子放入嬰兒床並給他/她奶瓶？ ☐ 是 ☐ 否

安全

6. 您每次開車帶孩子出門時，是否讓孩子坐在後座的兒童安全座椅上，面朝後方？ ☐ 否 ☐ 是
7. 您家裡的清潔用品、藥品和火柴是否都已收好並上鎖？ ☐ 否 ☐ 是
8. 您是否將「毒性物質控制中心」的電話號碼 (800-222-1222) 貼在家用電話旁或存在手機裡？ ☐ 否 ☐ 是

成長中的孩子

9. 您對孩子的體重存在任何顧慮嗎？ ☐ 是 ☐ 否
10. 您的孩子是否會發出「嘎」、「嗎」或「吧」的聲音？ ☐ 還不會 ☐ 稍微 ☐ 是，經常
11. 您的孩子會翻身嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常
12. 您的孩子會將玩具從一隻手換到另一隻手嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常
13. 您的孩子會將兩樣物品互相敲打嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常

家庭生活

14. 您的孩子會看電視或影片嗎？ ☐ 是 ☐ 否
15. 您的孩子是否曾被獨自拋下，例如在家裡或車內？ ☐ 是 ☐ 否
16. 從孩子上一次檢查至今，您的家人或孩子是否經歷任何重大變故（例如生病、搬家、換工作或失業、分居或離婚、家人去世）？ ☐ 是 ☐ 否
    如果回答「是」，請列示：_____

由孩子的母親回答：

過去2週以來，您受以下任何問題困擾的頻率是？

17. 做事失去興致或樂趣？ ☐ 完全不會 ☐ 有幾天 ☐ 一半時間以上 ☐ 幾乎每天
18. 感覺心情低落、抑鬱或無望？ ☐ 完全不會 ☐ 有幾天 ☐ 一半時間以上 ☐ 幾乎每天

KAISER PERMANENTE®