

DEVELOPMENTAL TASKS									
NORMAL	ABNORMAL			NORMAL	ABNORMAL				
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	Sits with support		<input type="checkbox"/>	<input type="checkbox"/>	Raking hand pattern			
<input type="checkbox"/>	<input type="checkbox"/>	Passes hand to hand		<input type="checkbox"/>	<input type="checkbox"/>	Turns to voice			
<input type="checkbox"/>	<input type="checkbox"/>	Rolls over		<input type="checkbox"/>	<input type="checkbox"/>	Babbles, laughs			
<input type="checkbox"/>	<input type="checkbox"/>	Reaches for toys		<input type="checkbox"/>	<input type="checkbox"/>	Recognizes strangers			
<input type="checkbox"/>	<input type="checkbox"/>	Bears weight							
Describe abnormal findings:									
DIET/ NUTRITION			IMMUNIZATIONS				LABORATORIES		
Breast	<input type="checkbox"/>	<input type="checkbox"/>	DTaP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#1	<input type="checkbox"/>	<input type="checkbox"/>
Formula _____	<input type="checkbox"/>	<input type="checkbox"/>	IPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#2	<input type="checkbox"/>	<input type="checkbox"/>
Fruits	<input type="checkbox"/>	<input type="checkbox"/>	Hib	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#3	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride supplements	<input type="checkbox"/>	<input type="checkbox"/>	Hep B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#1	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>
(Pureed solid food)	<input type="checkbox"/>	<input type="checkbox"/>						yes	no
Iron fortified cereal	<input type="checkbox"/>	<input type="checkbox"/>	Immunization for age completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<i>SUBJECTIVE</i> _____									
<i>OBJECTIVE</i>									
HEIGHT	WEIGHT		HEAD CIRCUMFERENCE			HR	RR		
	NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL	Describe Physical findings		
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Head	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fontanelles	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
EOM	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Symmetrical	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Light Reflex	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ENT	<input type="checkbox"/>	<input type="checkbox"/>	Neuro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Hearing screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<i>ASSESSMENT</i> _____									
<i>PLAN</i> _____									
					ANTICIPATORY GUIDANCE				
Provider's Signature					Next Appointment				
Provider's Stamp					Syrup of Ipecac Accident prevention: Falls, never leave baby unattended in a tub of water, electrical outlets and plugs, poisons, medicines, small objects Teething Effects of passive smoking BBTD				
Date									
DETAINEE LABEL									