

**New Jersey Department of Health and Senior Services
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
INFANCY: 6 Months**

DATE: _____

Child's Name		Date of Birth																																									
Allergies		Birth Weight																																									
Illnesses/Injuries/Problems/Concerns		Current Medications																																									
RN:		APN/PA/MD/DO:																																									
SUBJECTIVE		SUBJECTIVE																																									
Y N <input type="checkbox"/> <input type="checkbox"/> My baby eats some solid foods <input type="checkbox"/> <input type="checkbox"/> My baby says things like "da da" or "ba ba" <input type="checkbox"/> <input type="checkbox"/> My baby sits with help/support <input type="checkbox"/> <input type="checkbox"/> I am concerned that I have frequent times of sadness <input type="checkbox"/> <input type="checkbox"/> My baby can pick up objects <input type="checkbox"/> <input type="checkbox"/> My baby seems happy <input type="checkbox"/> <input type="checkbox"/> My baby recognizes me Diet: _____ <input type="checkbox"/> Vitamin Supplements <input type="checkbox"/> WIC Referral <input type="checkbox"/> Newborn Hearing Screening Results <input type="checkbox"/> Review Immunization Record <input type="checkbox"/> Lead Risk Assessment (verbal) Elimination: _____ Sleep: _____ Other: _____		<input type="checkbox"/> Review of Family History _____ _____ _____ <input type="checkbox"/> Review of Systems _____ _____ _____ _____																																									
HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)		OBJECTIVE: PHYSICAL																																									
<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 Care Seat <input type="checkbox"/> Child Care Issues <input type="checkbox"/> Passive Smoke <input type="checkbox"/> Oral Health Care <input type="checkbox"/> Lead Poison Prevention		<table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">N A</td> <td></td> <td style="text-align: center;">N A</td> </tr> <tr> <td>General Appearance</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Lungs</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Skin</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Chest</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Head/Fontanels</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Cardiovascular/Pulses</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Eyes</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Abdomen</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Ears</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Genitalia</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Nose</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Spine</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Oropharynx/Teeth</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Extremities</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Dental Structure/Tongue</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td>Neurological</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Mental Health</td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td></td> <td></td> </tr> </table>			N A		N A	General Appearance	<input type="checkbox"/> <input type="checkbox"/>	Lungs	<input type="checkbox"/> <input type="checkbox"/>	Skin	<input type="checkbox"/> <input type="checkbox"/>	Chest	<input type="checkbox"/> <input type="checkbox"/>	Head/Fontanels	<input type="checkbox"/> <input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/> <input type="checkbox"/>	Eyes	<input type="checkbox"/> <input type="checkbox"/>	Abdomen	<input type="checkbox"/> <input type="checkbox"/>	Ears	<input type="checkbox"/> <input type="checkbox"/>	Genitalia	<input type="checkbox"/> <input type="checkbox"/>	Nose	<input type="checkbox"/> <input type="checkbox"/>	Spine	<input type="checkbox"/> <input type="checkbox"/>	Oropharynx/Teeth	<input type="checkbox"/> <input type="checkbox"/>	Extremities	<input type="checkbox"/> <input type="checkbox"/>	Dental Structure/Tongue	<input type="checkbox"/> <input type="checkbox"/>	Neurological	<input type="checkbox"/> <input type="checkbox"/>	Mental Health	<input type="checkbox"/> <input type="checkbox"/>		
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OBJECTIVE: SCREENING		ASSESSMENT (Problem List)																																									
WEIGHT KG/LB PERCENTILE:	HEIGHT CM/IN PERCENTILE:	HEAD CIR. PERCENTILE:	PLAN _____ _____ _____																																								
	N A																																										
Hearing	<input type="checkbox"/> <input type="checkbox"/>	_____	REFERRALS _____ _____																																								
Vision	<input type="checkbox"/> <input type="checkbox"/>	_____																																									
Development	<input type="checkbox"/> <input type="checkbox"/>	_____																																									
Behavior	<input type="checkbox"/> <input type="checkbox"/>	_____																																									
Social/Emotional	<input type="checkbox"/> <input type="checkbox"/>	_____																																									
Gross Motor	<input type="checkbox"/> <input type="checkbox"/>	_____																																									
Fine Motor	<input type="checkbox"/> <input type="checkbox"/>	_____																																									
RN ASSESSMENT:		APN/PA/MD/DO SIGNATURE:																																									
RN PLAN:																																											
RN SIGNATURE:		REFERRALS:																																									
NEXT VISIT: 9 MONTHS OF AGE		IMMUNIZATIONS: <input type="checkbox"/> Given <input type="checkbox"/> Up to date																																									

