

Child's Name: _____ Date of Birth: _____

Diagnosis: _____

Allergies: _____

Medications: _____

Today's Date: _____ Form Completed By: _____

Please answer the following questions about your child's health and development so we can help with your needs.

<i>Staff Only</i>	Staying Healthy	YES	SOME -TIMES	NO
F/U	Medical Home: _____			
	1. Do you have a medical home (family doctor or clinic) that you go to when your baby is sick or needs a check-up?			
	2. Does your baby have regular check-ups with the medical home provider? (2, 4, 6, 9, & 12 months)			
	3. Are your baby's immunizations up-to-date?			
	4. Are you happy with your baby's weight?			
	5. Do you clean your baby's mouth at least daily?			
	6. Has your baby started eating baby food (4-9 months) and/or table food (9-12 months)?			
	7. Does your baby sleep well?			
	8. Does your baby have at least one dirty diaper a day?			
	9. Do you regularly fasten your baby into a car seat?			
	10. Do you understand the dangers of second-hand smoke to babies?			

Name: _____ ID #: _____

Staff Only	Managing Your Infant's Healthcare	YES	SOME -TIMES	NO
F/U	Drugstore: _____			
	11. Do you understand your baby's health problems?			
	12. Do you participate in your baby's treatment? (medications, exercises, therapy)			
	13. Are you being taught how to do your baby's treatments?			
	14. Are you continuing your baby's treatments at home when the healthcare providers aren't present?			
	15. Do you feel that your baby's identified needs are being met?			
	16. Do you know when, how much, and why your baby gets medications? (prescription and over-the-counter, like <i>Tylenol</i>)			
	17. Do you know the side effects of your baby's medications?			
	18. Are you able to get the medications, supplies, and/or equipment your baby needs?			
	19. Do you know how to use your baby's insurance and/or medical card?			

Name: _____ ID #: _____

<i>Staff Only</i> F/U	Interacting with Others	YES	SOME -TIMES	NO
	20. Has your baby started making noises?			
	21. Does your baby react to things around him/her?			
	22. Do you and your baby get to have some fun together every day? (playing games, reading, singing)			
	23. Do you have time to take care of some of your own needs?			
<i>Staff Only</i> F/U	Children's Rehabilitation Service Satisfaction	YES	SOME -TIMES	NO
	24. Are you pleased with the care you receive at CRS?			

What would you like to see done differently:

Information You Would Like to Have:

- | | | |
|--|---|---------------------------------------|
| <input type="radio"/> Growth & Development | <input type="radio"/> Counseling | <input type="radio"/> Social Security |
| <input type="radio"/> Early Intervention | <input type="radio"/> Assistance Programs | <input type="radio"/> Transportation |
| <input type="radio"/> Health Information | <input type="radio"/> Medicaid | <input type="radio"/> Other: _____ |

Your Comments:

