THE 6 MONTH CHECK UP

Please respond to the following items by marking a “+” if your child exhibits the behavior and a “-” if your child does not exhibit the behavior. This information will assist your child’s pediatrician in performing a comprehensive evaluation of his/her language development.

1. Does your child startle or blink eyes in response to sudden loud noises?
2. Does your child smile or stop crying when he hears a familiar voice?
3. Does your child make gurgling or babbling noises when left alone and when playing with you?
4. Does your child watch your face when you speak to him/her?
5. Does your child turn his/her eyes and head in search of sounds that come from behind or the side?
6. Does your child respond to his/her name by looking at the speaker?
7. Does your child react positively to the sight of favorite toys: increased kicking, waving arms, facial expressions, etc.?
8. Does your child vocalize pleasure & displeasure sounds (laughs, giggles, cries, fusses)?
9. Are your child’s babbling sounds more speech-like with many different sounds, including p, b and m?

Is there any family history of hearing or speech disorders?  ____ YES  ____ NO, If so, please describe briefly:

__________________________________________________________

__________________________________________________________

Child’s name:__________________________ Age:_________ Date of visit:_________________