10-Month-Old Child Health Examination Questionnaire

Furigana		Date of Birth:	Family Makeup: Family members living with the child (excluding the child themselves)						
Child's Name		[Year] ____ [Month] __ [Day] __ (Child Number: ___)	Relation	Age	Relation	Age	Relation	Age	
Address	Otsu City (School District: _____) Do you have plans to move in the near future? (No ・ Yes)								
	TEL		TEL						
	Contact① Father ・ Mother ・ Grandfather ・ Grandmother ・ Other (____)		Contact② Father ・ Mother ・ Grandfather ・ Grandmother ・ Other ( )						
Birth Height: _____ cm	Birth Weight: _____ g	Length of Pregnancy: ____ weeks	Currently in Childcare?: Yes (____ Nursery school, Kindergarten, etc.) ・ No Plans for Next Year: Nursery school, Kindergarten, etc. ・ At home ・ Undecided						

◆Please refer to your Maternal and Child Health Handbook (Boshi Techo), circle the applicable items, and fill in the parentheses when necessary.

A. Development	1. Growth & Development	・Can your child sit steadily without using their hands for support?	(_____ months)
		・Do they move by crawling on their belly?	(_____ months)
		・Do they move by crawling on their hands and knees?	(_____ months)
		・Do they pull themselves up to a standing position using furniture or support?	(_____ months)
		・Do they walk while holding onto something (such as furniture)?	(_____ months)
		・If you get down to their eye level, point, and say something like, "Look, a dog!" do they look in that direction?	(_____ months)
		・Do they enjoy mimicking your actions during playtime?	(_____ months)
		→If yes, what kind of actions do they mimic? (clapping hands, etc.)	[_____]
		・Do they experience shyness with strangers or follow you around often?	Yes (_____ months) ・ No
		・When did their first teeth start coming in?	(_____ months)
		・Can they transition on their own from lying on their stomach to sitting up, or from sitting up to lying on their stomach?	Yes ・ No
	2. What kind of sounds/noises has your child been making lately?		[ ]
	3. Do they turn toward soft sounds (such as paper tearing)?		1 Yes 2 No
	4. Do they show joy when seeing siblings or other small children?		1 Yes 2 No
	5. If you open your mouth and say "Ahhh," will they put food into an adult's mouth?		1 Yes 2 No
B. Medical History / Current Conditions	6. Do you have any concerns regarding allergies?		1 No 2 Yes (Dermatitis / Food / Other: _____)
	7. For those who answered "Yes" to question 6: Are they currently receiving treatment?		1 No 2 Yes (_____)
	8. Has the child ever had a convulsion or seizure?		1 No 2 Yes (Temperature at the time: ____° C)
	9. Has the child ever had a serious illness, or are they currently visiting a hospital for any condition?		1 No 2 Yes (_____)
C. Lifestyle Habits	10. What kind of play or activities does your child enjoy?		[ ]
	11. How much time does the child spend watching TV or using tablets/smartphones per day?		Total: ____ hours
	12. Do you find the child difficult to care for (e.g., they cry often, refuse to eat, or do not sleep)?		1 No 2 Yes
	13. Regarding stools (poop): Does the child go every day?		1 Yes (___ times per day) 2 No (1 time every ___ days)
	14. Regarding daily routine/rhythm: (Please shade in the hours the child is asleep.)		0 6 12 18 24
D. Diet / Eating	15. Baby Food (Solid Food)	・Number of meals:	(___ times per day)
		・Approximate amount and contents per meal (e.g., 1 bowl of soft rice)	Main food (_____) Other (_____)
		・Side dishes Please circle the foods your child has eaten:	White fish ・ Tofu ・ Egg ・ Chicken ・ Beef ・ Tuna ・ Salmon
		・Seasoning Please circle the items you have used:	Dashi (soup stock) ・ Soy sauce ・ Miso ・ Oil
		・Formula	(_____cc, _____times per day)
		・Breast milk	(_____ cc per feeding, _____ times per day)
		・Tea	(_____ cc)
		・Other	(Type: _____ , _____ cc)
		・How do you prepare foods like potatoes?	Mashed ・ Minced/Finely chopped ・ Bite-sized pieces
	16. Do you allow the child to eat with their hands?		Yes ・ For snacks only ・ No
	17. Are you practicing using a straw or a cup?		1 Yes 2 No
	18. Does the child eat meals together with the family?		1 Yes 2 No
E. Childcare	19. When do you feel most happy or rewarded while raising your child?		[_____]
	20. Do you often feel frustrated or find childcare difficult?		1 No 2 Not sure 3 Yes (When: _____)
	21. Please write down any other concerns or things you would like to discuss.		[_____]

Please also write down if you have anything you would like to discuss regarding yourself (e.g., your own health, family relationships, etc.).

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