12 Month Checklist

Date of Visit: _____

Nurse Code: _____ Age of Child: _____
Client Initials: _____ Client number: _____
Child weight: _____ Child length: _____

INFANT FEEDING

1. What is your child's main source of milk intake?
   - ☐ Breast Milk
   - ☐ Cows Milk
   - ☐ Infant Formula
   - ☐ Other

2. Did you ever attempt to breastfeed your child?
   - ☐ Yes
   - ☐ No

3. Including times of weaning, what is the total time your baby was breastfed in months and weeks?
   _____days _____weeks _____ months

4. What age was your child when you commenced cow's milk as the main source of milk intake?
   _____days _____weeks _____ months

5. Has your child learnt to take fluids from a cup?
   - ☐ Yes _____months
   - ☐ No

6. What other fluid is your baby having?
   - ☐ Water
   - ☐ Cordial
   - ☐ Sports drink
   - ☐ Juice
   - ☐ Soft Drink
   - ☐ Other

7. Have you commenced or recommenced paid employment?
   - ☐ Yes
   - ☐ No

8. Are you able to continue breastfeeding while working?
   - ☐ Yes
   - ☐ No
   - ☐ N/A

Discuss continuation of breastfeeding. Cup feeding - no bottles. Other fluids - discourage or limit juice intake max 100mls per day diluted with water, avoid cordials, soft drinks, tea, sport drinks

9. Is your child having the normal family diet ? i.e.: you are not preparing separate food
   - ☐ Yes
   - ☐ No

10. How many meals does your child have each day?
    - ☐ 1
    - ☐ 3
    - ☐ 2
    - ☐ more than three

11. What snacks does your child eat between meals?
    _____
    _____

12. Have you identified any issues with giving food? Prompts like chewing, swallowing
    _____
    _____

13. Do you find you offer food when you are unsure what baby wants i.e. tired or upset?
    - ☐ Yes ☐ No

14. Is food used as a reward for a desired behaviour?
    - ☐ Yes ☐ No

15. Do you eat your meals together as a family at least once a day?
    - ☐ Yes ☐ No

16. Do you have the television on when you are having your meals together?
    - ☐ Yes ☐ No

Discuss age appropriate portion sizes (approx 1 cup), consistency (chopped foods, promote chewing),finger foods and self feeding, family foods, cup drinking/ transition from bottle to cup, offering foods from five food groups (variety, nutritional requirements), educate the need for a healthy diet as milk not meeting all there nutritional requirements, fresh fruit instead of juice, healthy snacks.

<u>YOUR BABY & PHYSICAL ACTIVITY</u>

17. What new things is your baby doing now?
    - ☐ Sitting
    - ☐ Crawling well
    - ☐ Climbing
    - ☐ Pulling to stand
    - ☐ Standing holding on
    - ☐ Standing
    - ☐ Cruising
    - ☐ Supported walking
    - ☐ Unsupported walking
    - ☐ Rolls ball forward
    - ☐ Kicks ball forwards
    - ☐ Walks backwards
    - ☐ Throws ball underhand
    - ☐ Throws ball overhand
    - ☐ Walks up and down steps
    - ☐ Other

18. What activities are you and baby doing together?

    _____
    _____
    _____
    _____

19. and how much time during the week does your child spend

	Number of days/week	Number of hrs/day or	Number of mins/day
Playing PC games			
Handheld games			
Watching DVD's			
Watching free to air TV			
Watching paid TV			

20. Does your television remain on regardless if anyone is watching?
    - ☐ Yes
    - ☐ No

YOUR PHYSICAL ACTIVITY & NUTRITION

Discuss physical recovery since last visit

21. How many times per week are you doing any regular exercise or activity of moderate intensity lasting for at least 30 minutes (this can be in 3 x 10 minute sessions)? **(Moderate – will cause slight, but noticeable increase in breathing and heart rate and may cause light sweating – i.e.: brisk walk, swimming, exercise class, dancing)**
    - ☐ Never
    - ☐ Seldom
    - ☐ 1 – 2 times per week
    - ☐ 3 – 4 times per week
    - ☐ 5 or more times per week

Assess what stage the mother is at with the Readiness *to Change* flowchart

22. Using the chart what *Readiness to Change Stage* are they currently in
    - ☐ One
    - ☐ Two
    - ☐ Three
    - ☐ Four
    - ☐ Five

23. Do you intend to become more physically active in the next 6 months?
    - ☐ Yes
    - ☐ No

Go thorough discussion points on behaviour change, benefits, barriers and enablers, confidence and goal setting. Discuss any physical activity goals that were put into place since the last visit. Reassess the *Readiness to Change* flowchart

24. What barriers / enablers are in place?

    _____
    _____

25. What goals have been put in place?

    _____
    _____

SOCIAL SUPPORT

26. What involvement with the baby does your partner have?

    _____
    _____

27. Do you have support and help from family and friends?
    - ☐ Yes
    - ☐ No

28. Are you aware of any community support like playgroups, baby gyms etc
    - ☐ Yes
    - ☐ No

29. Are you involved in any groups?
    - ☐ Yes
    - ☐ No

30. Are you in contact with the Child and Family Nurses who work out of local baby clinics?
    - ☐ Yes
    - ☐ No

Have you visited your local doctor since my last visit?

□ Yes □ No □ Medical centre

Discuss importance of supportive environments and keeping in contact with local baby clinics

COMMENTS

_____

_____

_____

_____

Other topics discussed:

_____

_____

_____

_____

Signature: _____