MONTHLY REPORT
3 TO 4 MONTHS

BRIDGES
CHILD PLACEMENT AGENCY

Name of Child:_____ **Age:** _____
Caseworker: _____ **County:**_____ **For Month, Year**_____

The items listed in each section below represent things a child of FOUR MONTHS of age should be doing. Mark the box next to the item if it represents something that is true of your child at this time.

0-2 months	3-4 months
Social/Emotional	
☐ Begins to smile at people ☐ Can briefly calm himself (may bring hands to mouth and suck on hand) ☐ Tries to look at parent	☐ Smiles spontaneously, especially at people ☐ Likes to play with people and might cry when playing stops ☐ Copies some movements and facial expressions, like smiling or frowning
Language/Communication	
☐ Coos, makes gurgling sounds ☐ Turns head toward sounds	☐ Begins to babble ☐ Babbles with expression and copies sounds he hears ☐ Cries in different ways to show hunger, pain, or being tired
Cognitive (learning, thinking, problem solving):	
☐ Pays attention to faces ☐ Begins to follow things with eyes and recognize people at a distance ☐ Begins to act bored (cries, fussy) if activity doesn't change	☐ Lets you know if she is happy or sad ☐ Responds to affection ☐ Reaches for toy with one hand ☐ Uses hands and eyes together, such as seeing a toy and reaching for it ☐ Follows moving things with eyes from side to side ☐ Watches faces closely ☐ Recognizes familiar people and things at a distance
Movement/Physical Development:	
☐ Can hold head up and begins to push up when lying on tummy ☐ Makes smoother movements with arms and legs	☐ Holds head steady, unsupported ☐ Pushes down on legs when feet are on a hard surface ☐ May be able to roll over from tummy to back ☐ Can hold a toy and shake it and swing at dangling toys ☐ Brings hands to mouth ☐ When lying on stomach, pushes up to elbows
Important Miscellaneous Items: Notify your Doctor, (and placement worker, and county case worker) if, by the end of TWO MONTHS of age your child:	**Important Miscellaneous Items: Notify your Doctor, (and placement worker, and county case worker) if, by the end of FOUR MONTHS of age your child:**
☐ Doesn't respond to loud sounds ☐ Doesn't watch things as they move ☐ Doesn't smile at people ☐ Doesn't bring hands to mouth ☐ Can't hold head up when pushing up when on tummy	☐ Doesn't watch things as they move ☐ Doesn't smile at people ☐ Can't hold head steady ☐ Doesn't coo or make sounds ☐ Doesn't bring things to mouth ☐ Doesn't push down with legs when feet are placed on a hard surface ☐ Has trouble moving one or both eyes in all directions

Family Visits/Contacts:

Does the child have regular contacts/visits with family members? ☐ Yes ☐ No

If YES, fill in the following:

Date & Time ex: 1/1/09; 3-4PM	**Location** ex: visitation center,foster home, parents' home	**Type of contact** ex: face to face, phone, email, etc.	**With Whom** indicate names & relationship, ex: "Susy Smith - mother"

Other Appointments: (visits by caseworkers, GAL's,Bridges staff, medical/therapy,etc.)

Date	Contact	Reason for Visit

Additional Important Dates:

Most recent: Physical exam:_____ Dental exam: _____ Eye exam: _____

Date of most recent doctor's visit_____Treated for: _____

Next scheduled medical appointment: _____

Report submitted by: _____ **Date:** _____

Print name: _____