

## 2 MONTH DEVELOPMENTAL CHECKLIST

Name of patient \_\_\_\_\_

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|--|-----|----|
| 1. Is your baby holding his/her head up for short periods of time? | YES | NO |
| 2. Is your baby raising his/her chest up when on belly?            | YES | NO |
| 3. Is your baby beginning to follow you with his/her eyes?         | YES | NO |
| 4. Does your baby smile in response to you?                        | YES | NO |
| 5. Is your baby cooing?  | YES | NO |
| 6. Does your baby respond to your voice?                           | YES | NO |
| 7. Has your baby stopped clenching his/her fists tightly?          | YES | NO |