

6 MONTH DEVELOPMENTAL CHECKLIST

Name of patient _____

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| 1. Is your baby sitting up with no support? | YES | NO |
| 2. Is your baby rolling in both directions? | YES | NO |
| 3. Does your baby transfer objects from hand to hand? | YES | NO |
| 4. Is your baby babbling? | YES | NO |
| 5. Is your baby recognizing that someone is a stranger? | YES | NO |