6 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have concerns about your baby?	NO	YES
2	Does your baby ever appear cross-eyed?	NO	YES
3	Has your baby had any problems with shots or immunizations?	NO	YES
4	Does your baby receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

5	Is your baby breastfeeding?	YES	NO
	a. How many times a day does your baby breastfeed?		
6	Is your baby taking (drinking) formula?	YES	NO
	a. How many ounces of formula total each day?		
	b. Which formula are you feeding your baby?		
7	Are you giving your baby any solid foods?	YES	NO
8	Is your baby taking an infant multivitamin D supplement? (If your baby is taking more than 34 ounces of formula per day, you do not need to be giving a supplement).	YES	NO

Oral Health

9	Does your child sleep with a bottle?	NO	YES
10	Does your baby wake at night to eat?	NO	YES
11	Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your baby's teeth and gums?	YES	NO
12	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

13	Does your baby have any problems with bowel movements (going poop)?	NO	YES
14	Is your baby urinating (peeing) well?	YES	NO

Sleep

15 Does your baby sleep at least 6 to 8 hours without waking up at night?	YES	NO
16 Does your baby fall asleep on his/her own?	YES	NO
17 Do you have a bedtime routine?	YES	NO

Development

18 Babbling and imitating sounds?	YES	NO
19 Responds to his or her name?	YES	NO
20 Rolling over both ways?	YES	NO
21 Makes eye contact?	YES	NO
22 Reaches for things?	YES	NO
23 Sits unassisted for a few seconds?	YES	NO
24 Do you read to your baby every day?	YES	NO
25 Do you play games like peek-a-boo or play music with your baby?	YES	NO

Social Stressors

26 Are you having any family stress?	NO	YES	
27 Do you feel you receive the support you need?	YES	NO	
28 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
29 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
30 Do you ever feel angry or frustrated with your baby?	NO	YES	

Safety

31 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
32 Does your baby wear any jewelry (including necklaces)?	NO	YES
33 Do you hold or carry hot liquids around the baby?	NO	YES
34 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
35 Does anyone smoke or vape around your baby?	NO	YES
36 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO
37 Are you using a shade or sunscreen if your baby is in the sun more than 15-30 minutes?	YES	NO

38 Do you keep plastic bags and latex balloons away from your baby?	YES	NO
39 Is your water heater turned to below 120 degrees?	YES	NO
40 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO
41 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO
42 Does your baby use a seated infant walker with wheels?	NO	YES

Postnatal Depression

Instructions: *Please check the box to the left of the answer that comes closest to how you have felt* ***in the past seven (7) days****, not just how you feel today:*

1 I have been able to laugh and see the funny side of things:

☐As much as I always could ☐Not quite so much now ☐Definitely not so much now ☐Not at all

2 I have looked forward with enjoyment to things:

☐As much as I ever did ☐Rather less than I used to ☐Definitely less than I used to ☐Hardly at all

3 I have blamed myself unnecessarily when things went wrong:

☐Yes, most of the time ☐Yes, some of the time ☐Not very often ☐No, never

4 I have been anxious or worried for no good reason:

☐No, not at all ☐Hardly ever ☐Yes, sometimes ☐Yes, very often

5 I have felt scared or panicky for no good reason:

☐Yes, quite a lot ☐Yes, sometimes ☐No, not much ☐No, not at all

6 Things have been getting to me:

☐Yes, most of the time I haven't been able to cope at all ☐ Yes, sometimes I haven't been coping as well as usual ☐No, most of the time I have coped quite well ☐No, I have been coping as well as ever

7 I have been so unhappy that I have had difficulty sleeping:

☐Yes, most of the time ☐Yes, sometimes ☐No, not very much ☐No, not at all

8 I have felt sad or miserable:

☐Yes, most of the time ☐Yes, quite often ☐Not very often ☐No, not at all

9 I have been so unhappy that I have been crying:

☐Yes, most of the time ☐Yes, quite often ☐Only occasionally ☐No, never

10 The thought of harming myself has occurred to me:

☐Yes, quite often ☐Sometimes ☐Hardly ever ☐Never