Newborn 2 Weeks – 1 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 spit up or throw up a lot?	NO	YES
3	Do you have any concerns about skin color or rashes?	NO	YES
4	A rectal temperature of 100.4 or higher is a fever. Could you take your baby's rectal temperature if you needed to?	YES	NO

Feeding/Nutrition

5	Do you have any concerns about your baby's feedings?	NO	YES
6	Is your baby breastfeeding?	YES	NO
7	Is your baby taking breastmilk by the bottle?	YES	NO
8	Is your baby taking (drinking) formula?	YES	NO
	a. Which formula are you feeding your baby?		
9	Is your baby feeding at least 8 times a day?	YES	NO
10	Are you feeding your baby anything other than breastmilk or formula?	NO	YES
11	Is your baby getting an infant multivitamin or a vitamin D supplement?	YES	NO

Elimination

12	How many bowel movements is your baby having in a day?		
	a. What color are your baby's poops?		
13	Is your baby urinating (peeing) well?	YES	NO

Sleep

14	Do you have any questions or concerns about your baby's sleep habits?	NO	YES

Social Stressors

15 If there are other children in the house, are they adjusting well to your newborn?	YES	NO	N/A
16 Are you having any family stress?	NO	YES	
17 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
18 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
19 Do you feel you receive the support you need?	YES	NO	
20 Do you ever feel angry or frustrated with your baby?	NO	YES	

Development

21 Does your baby turn his/her head towards the direction of sound?	YES	NO
22 Does your baby follow parent with his/her eyes?	YES	NO
23 Does your baby recognize parents' voices?	YES	NO
24 Does your baby respond to your face or bright light?	YES	NO
25 Is your baby responsive to calming actions when upset?	YES	NO
26 Does your baby raise head slightly when on tummy?	YES	NO
27 Does your baby have tummy time while awake?	YES	NO

Safety

28 Does your baby sleep on his/her back?	YES	NO
29 Where does your baby sleep?	Crib/Bassinet	Parents' bed
30 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
31 Does your baby wear any jewelry (including necklaces)?	NO	YES
32 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
33 Does anyone smoke or vape around your baby?	NO	YES
34 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO

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