

4 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 cry for longer than 30 minutes at a time?	NO	YES
3	Has your baby had any problems with shots or immunizations?	NO	YES

Feeding/Nutrition

4	Is your baby breastfeeding?	YES	NO
	a. How many times a day does your baby breastfeed?		
	b. If your baby is getting breast milk, are you giving bottles of pumped milk?	YES	NO
5	Is your baby taking (drinking) formula?	YES	NO
	a. How many times a day does your baby drink formula?		
	b. Which formula are you feeding your baby?		
6	Are you feeding your baby anything other than breastmilk or formula?	NO	YES
7	Is your baby getting an infant multivitamin or a vitamin D supplement?	YES	NO

Oral Health

8	Do you put your baby to bed with a bottle?	NO	YES
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Elimination

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

Sleep

11	Do you put baby in the crib when drowsy, not fully asleep?	YES	NO
12	Do you have any questions or concerns about your baby's sleep habits?	NO	YES

Development

13 Does your baby smile when approached?	YES	NO
14 Does your baby coo, babble, and laugh?	YES	NO
15 Does your baby move all arms and legs well?	YES	NO
16 Does your baby try to reach for objects?	YES	NO
17 Does your baby roll around?	YES	NO
18 Does your baby lift his/her upper body on elbows?	YES	NO
19 Does your baby lift his/her head well when lying on tummy?	YES	NO
20 Does your baby have good head control?	YES	NO
21 Do you hold, cuddle, talk, and play with your baby?	YES	NO

Social Stressors

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

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
35 Are you using a shade or sunscreen if your baby is in the sun more than 15-30 minutes?	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:

<input type="checkbox"/> As much as I always could	<input type="checkbox"/> Not quite so much now	<input type="checkbox"/> Definitely not so much now	<input type="checkbox"/> Not at all
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- 2 I have looked forward with enjoyment to things:

<input type="checkbox"/> As much as I ever did	<input type="checkbox"/> Rather less than I used to	<input type="checkbox"/> Definitely less than I used to	<input type="checkbox"/> Hardly at all
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- 3 I have blamed myself unnecessarily when things went wrong:

<input type="checkbox"/> Yes, most of the time	<input type="checkbox"/> Yes, some of the time	<input type="checkbox"/> Not very often	<input type="checkbox"/> No, never
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- 4 I have been anxious or worried for no good reason:

<input type="checkbox"/> No, not at all	<input type="checkbox"/> Hardly ever	<input type="checkbox"/> Yes, sometimes	<input type="checkbox"/> Yes, very often
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- 5 I have felt scared or panicky for no good reason:

<input type="checkbox"/> Yes, quite a lot	<input type="checkbox"/> Yes, sometimes	<input type="checkbox"/> No, not much	<input type="checkbox"/> No, not at all
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- 6 Things have been getting to me:

<input type="checkbox"/> Yes, most of the time I haven't been able to cope at all	<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual	<input type="checkbox"/> No, most of the time I have coped quite well	<input type="checkbox"/> No, I have been coping as well as ever
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- 7 I have been so unhappy that I have had difficulty sleeping:

<input type="checkbox"/> Yes, most of the time	<input type="checkbox"/> Yes, sometimes	<input type="checkbox"/> No, not very much	<input type="checkbox"/> No, not at all
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- 8 I have felt sad or miserable:

<input type="checkbox"/> Yes, most of the time	<input type="checkbox"/> Yes, quite often	<input type="checkbox"/> Not very often	<input type="checkbox"/> No, not at all
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- 9 I have been so unhappy that I have been crying:

<input type="checkbox"/> Yes, most of the time	<input type="checkbox"/> Yes, quite often	<input type="checkbox"/> Only occasionally	<input type="checkbox"/> No, never
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- 10 The thought of harming myself has occurred to me:

<input type="checkbox"/> Yes, quite often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Hardly ever	<input type="checkbox"/> Never
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