### 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

#### 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Doesn’t Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Does your baby coo, babble, and laugh?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Does your baby move all arms and legs well?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Does your baby try to reach for objects?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Does your baby roll over?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Does your baby lift his/her upper body on elbows?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Does your baby have good head control?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Do you hold, cuddle, talk, and play with your baby?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Social Stressors

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 If there are other children in the house, are they adjusting well to your baby?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Are you having any family stress?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Within the past 12 months have you worried that your food would run out before you got money to buy more?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Within the past 12 months did you run out of food and you didn't have money to get more?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Do you ever feel angry or frustrated with your baby?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Does your baby sleep on his/her back?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Where does your baby sleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Does your baby wear any jewelry (including necklaces)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Does your baby ride in a rear-facing safety seat, in the back seat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Does anyone smoke or vape around your baby?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Do you have working smoke and carbon monoxide detectors in your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15-30 minutes?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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