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, nurse practitioner or physician's assistant (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 baby 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 (size of a grain of rice) to clean your baby's teeth and gums?	YES	NO	No Teeth
12	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO	
13	Has any caregiver had cavities/dental decay in the past year?	NO	YES	

Elimination

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

Sleep

16	Does your baby fall asleep on his/her own?	YES	NO
17	Do you have a bedtime routine?	YES	NO

Development

18	Does your baby babble and imitate sounds?	YES	NO
19	Does your baby respond to his/her name?	YES	NO
20	Does your baby roll over both ways?	YES	NO
21	Does your baby make eye contact?	YES	NO
22	Does your baby reach for things?	YES	NO
23	Does your baby stay sitting up by himself/herself 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
26	Does your baby get supervised floor time every day?	YES	NO

Social Stressors

27	Are you having any family stress?	NO	YES	
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	If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15-30 minutes?	YES	NO	Doesn't apply

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