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
5	Does your baby have a parent or full sibling who has been diagnosed with eczema, asthma or environmental allergies?	NO	YES

Feeding/Nutrition

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

Elimination

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

Sleep

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

Social Stressors

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

Development

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

Safety

30	Does your baby sleep on his/her back?	YES	NO
31	Where does your baby sleep?	Crib/Bassinet	Other
32	Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
33	Does your baby wear any jewelry (including necklaces)?	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

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