

2 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

Feeding/Nutrition

3 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
4 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?		
5 Are you feeding your baby anything other than breastmilk or formula?	NO	YES
6 Is your baby getting an infant multivitamin or a vitamin D supplement?	YES	NO

Elimination

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

Sleep

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

Social Stressors

10	If there are other children in the house, are they adjusting well to your newborn?	YES	NO	Doesn't apply
11	Are you having any family stress?	NO	YES	
12	Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
13	Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
14	Do you ever feel angry or frustrated with your baby?	NO	YES	

Development

15	Does your baby smile at the sound of a parent's voice?	YES	NO
16	Does your baby make cooing noises?	YES	NO
17	Does your baby watch a parent walk across the room?	YES	NO
18	Can your baby briefly hold an object when you put it in your baby's hand?	YES	NO
19	Does your baby lift his/her head and chest when lying on tummy?	YES	NO

Safety

20	Is your baby swaddled when sleeping?	NO	YES
21	Does your baby sleep on his/her back?	YES	NO
22	Where does your baby sleep?	Crib/Bassinet	Other
23	Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
24	Does your baby wear any jewelry (including necklaces)?	NO	YES
25	Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
26	Does anyone smoke or vape around your baby?	NO	YES
27	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:

<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
--	--	---	-------------------------------------

- 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
--	---	---	--

- 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
--	--	---	------------------------------------

- 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
---	--------------------------------------	---	--

- 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
---	---	---------------------------------------	---

- 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
---	--	---	---

- 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
--	---	--	---

- 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
--	---	---	---

- 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
--	---	--	------------------------------------

- 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
---	------------------------------------	--------------------------------------	--------------------------------