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 Does your baby cry a lot? (more than 3 hours/day)?	NO	YES
4 Do you have any concerns about your baby's body movements?	NO	YES
5 Does your baby have a stuffy nose that makes it hard to feed?	NO	YES
6 Do you have any concerns about skin color or rashes?	NO	YES
7 Did you know that a rectal temperature of 100.4 or higher is a fever?	YES	NO
8 Could you take your baby's rectal temperature if you need to?	YES	NO

Feeding/Nutrition

9 Is your baby breastfeeding?	YES, Very well	Not Well. I have questions/concerns
10 Is your baby taking breastmilk by the bottle?	YES, Very well	Not Well. I have questions/concerns
11 Is your baby taking formula?	YES, Very well	Not Well. I have questions/concerns
a Which formula are you feeding your baby?		
12 Is your baby feeding at least 8 times a day?	YES, Very well	Not Well. I have questions/concerns
a Do you have concerns about your baby's feeding?		
13 Are you feeding your baby anything other than breastmilk or formula?	NO	YES

Elimination

Question		
14 Does your baby have any problems with bowel movements (going poop)?	NO	YES
a What color are your baby's poops?		
15 Is your baby urinating (peeing) well?	YES	NO

Sleep

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

Social Stressors

Question			
17 Has either parent been feeling down, depressed, or hopeless?	NO	YES	
18 Has either parent had little interest or pleasure in doing things they used to enjoy?	NO	YES	
19 If there are other children in the house, are they adjusting well to your baby?	YES	NO	N/A
20 Are you having any family stress?	NO	YES	
21 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
22 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
23 Do you feel that you receive the support you need?	YES	NO	
24 Do you ever feel angry or frustrated with your baby?	NO	YES	

Development

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

Safety

32 Does your infant sleep on his/her back?	YES	NO
33 Where does your baby sleep?	Crib/Bassinet	Parents’ bed
34 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
35 Does your baby wear any jewelry (including necklaces)?	NO	YES
36 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
37 Does anyone smoke or vape around your baby?	NO	YES
38 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO