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
3 Do you have any concerns about skin color or rashes?	NO	YES
4 Does your baby make a wheezing or whistling sound when breathing or have any trouble breathing?	NO	YES

Feeding/Nutrition

5 Is your baby breastfeeding?	YES, Very well	YES, OK	Not Well. I have questions/concerns
a How many times a day does your baby breastfeed?			
6 Is your baby taking (drinking) formula?	YES, Very well	YES, OK	Not Well. I have questions/concerns
a How many times a day does your baby take/drink formula?			
c Which formula are you feeding your baby?			
7 Are you feeding your baby anything other than breastmilk or formula?	NO	YES	
8 Do you give your baby any vitamins or supplements?	YES	NO	

Elimination

9 Does your baby have any problems with bowel movements (going poop)?	NO	YES
10 Urinating (peeing) well?	YES	NO

Sleep

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

Social Stressors

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

Development

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

Safety

26 Is your baby swaddled when sleeping?	NO	YES
27 Does your baby sleep on his/her back?	YES	NO
28 Where does your baby sleep?	Crib/Bassinet	Parents' bed
29 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
30 Does your baby wear any jewelry (including necklaces)?	NO	YES
31 Do you hold or carry hot liquids around the baby?	NO	YES
32 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
33 Does anyone smoke or vape around your baby?	NO	YES
34 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO