

TM  
**SWYC:**  
**2 months**

1 months, 0 days to 3 months, 31 days  
 V1.07, 4/1/17

Child's Name: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	No/At All	Somewhat	Very Much
Makes sounds that let you know he or she is happy or upset . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Seems happy to see you . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Follows a moving toy with his or her eyes . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Turns head to find the person who is talking . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Holds head steady when being pulled up to a sitting position . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Brings hands together . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Laughs . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Keeps head steady when held in a sitting position . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Makes sounds like "ga," "ma," or "ba" . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Looks when you call his or her name . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2

**BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)**

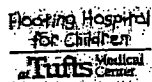
These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	No/At All	Somewhat	Very Much
Does your child have a hard time being with new people? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Does your child have a hard time in new places? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Does your child have a hard time with change? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Does your child mind being held by other people? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Does your child cry a lot? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Does your child have a hard time calming down? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is your child fussy or irritable? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is it hard to comfort your child? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is it hard to keep your child on a schedule or routine? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is it hard to put your child to sleep? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Is it hard to get enough sleep because of your child? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2
Does your child have trouble staying asleep? . . . . .	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2

**PARENT'S CONCERNS**

	No/At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have any concerns about your child's behavior?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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\*\*\*\*\* Please continue on the back \*\*\*\*\*

## FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

- |   |   |                         |                         |
|---|---|-------------------------|-------------------------|
| 1 | Does anyone who lives with your child smoke tobacco?  | <input type="radio"/> Y | <input type="radio"/> N |
| 2 | In the last year, have you ever drunk alcohol or used drugs more than you meant to?           | <input type="radio"/> Y | <input type="radio"/> N |
| 3 | Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? | <input type="radio"/> Y | <input type="radio"/> N |
| 4 | Has a family member's drinking or drug use ever had a bad effect on your child?               | <input type="radio"/> Y | <input type="radio"/> N |

- 5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.

- |   |  |                       |                       |                       |                       |
|---|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 6 | In general, how would you describe your relationship with your spouse/partner? | No tension            | Some tension          | A lot of tension      | Not applicable        |
|   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7 | Do you and your partner work out arguments with:                               | No difficulty         | Some difficulty       | Great difficulty      | Not applicable        |
|   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- 8 During the past week, how many days did you or other family members read to your child?  0  1  2  3  4  5  6  7

## EMOTIONAL CHANGES WITH A NEW BABY\*\*

Since you have a new baby in your family, we would like to know how you are feeling now. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

### 1 I have been able to laugh and see the funny side of things

- |   |   |  |                                    |
|---|---|--|------------------------------------|
| <input type="radio"/> 0 As much as I always could | <input type="radio"/> 1 Not quite so much now | <input type="radio"/> 2 Definitely not so much now | <input type="radio"/> 3 Not at all |
|---|---|--|------------------------------------|

### 2 I have looked forward with enjoyment to things

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="radio"/> 0 As much as I ever did | <input type="radio"/> 1 Rather less than I used to | <input type="radio"/> 2 Definitely less than I used to | <input type="radio"/> 3 Hardly at all |
|---|--|--|---------------------------------------|

### 3\* I have blamed myself unnecessarily when things went wrong

- |   |   |  |                                   |
|---|---|--|-----------------------------------|
| <input type="radio"/> 0 Yes, most of the time | <input type="radio"/> 1 Yes, some of the time | <input type="radio"/> 2 Not very often | <input type="radio"/> 3 No, never |
|---|---|--|-----------------------------------|

### 4 I have been anxious or worried for no good reason

- |  |                                     |  |   |
|--|-------------------------------------|--|---|
| <input type="radio"/> 0 No, not at all | <input type="radio"/> 1 Hardly ever | <input type="radio"/> 2 Yes, sometimes | <input type="radio"/> 3 Yes, very often |
|--|-------------------------------------|--|---|

### 5\* I have felt scared or panicky for no good reason

- |  |  |                                      |  |
|--|--|--------------------------------------|--|
| <input type="radio"/> 0 Yes, quite a lot | <input type="radio"/> 1 Yes, sometimes | <input type="radio"/> 2 No, not much | <input type="radio"/> 3 No, not at all |
|--|--|--------------------------------------|--|

### 6\* Things have been getting on top of me

- |  |   |  |  |
|--|---|--|--|
| <input type="radio"/> 0 Yes, most of the time I haven't been able to cope at all | <input type="radio"/> 1 Yes, sometimes I haven't been coping as well as usual | <input type="radio"/> 2 No, most of the time I have coped quite well | <input type="radio"/> 3 No, I have been coping as well as ever |
|--|---|--|--|

### 7\* I have been so unhappy that I have had difficulty sleeping

- |   |  |  |  |
|---|--|--|--|
| <input type="radio"/> 0 Yes, most of the time | <input type="radio"/> 1 Yes, sometimes | <input type="radio"/> 2 Not very often | <input type="radio"/> 3 No, not at all |
|---|--|--|--|

### 8\* I have felt sad or miserable

- |   |  |  |  |
|---|--|--|--|
| <input type="radio"/> 0 Yes, most of the time | <input type="radio"/> 1 Yes, quite often | <input type="radio"/> 2 Not very often | <input type="radio"/> 3 No, not at all |
|---|--|--|--|

### 9\* I have been so unhappy that I have been crying

- |   |  |   |                                   |
|---|--|---|-----------------------------------|
| <input type="radio"/> 0 Yes, most of the time | <input type="radio"/> 1 Yes, quite often | <input type="radio"/> 2 Only occasionally | <input type="radio"/> 3 No, never |
|---|--|---|-----------------------------------|

### 10\* The thought of harming myself has occurred to me

- |  |                                   |                                     |                               |
|--|-----------------------------------|-------------------------------------|-------------------------------|
| <input type="radio"/> 0 Yes, quite often | <input type="radio"/> 1 Sometimes | <input type="radio"/> 2 Hardly ever | <input type="radio"/> 3 Never |
|--|-----------------------------------|-------------------------------------|-------------------------------|

\*\*© 1987 The Royal College of Psychiatrists. Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786. Written permission must be obtained from the Royal College of Psychiatrists for copying and distribution to others or for republication (in print, online or by any other medium).

# blackmon



pediatrics

Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? \_\_\_\_\_

Can you describe your child's nutritional habits?

- |                                  |            |                              |         |                      |
|----------------------------------|------------|------------------------------|---------|----------------------|
| 1. Feeding:                      | Breast     | Formula                      | Milk    | Specify Brand: _____ |
| 2. Feeding Problems:             | Yes        | Yes                          | No      | Specify: _____       |
| 3. Taking multivitamin with iron | Yes        | Yes                          | No      |                      |
| 4. Number of diapers per day:    | Wet: _____ | Strong urine stream (males): | Yes     | No                   |
| 5. Water Source:                 | City _____ | Well                         | Spring  | Bottle _____         |
| 6. Taking solids:                | Cereal     | Fruits                       | Veggies | Meats _____          |
| 7. Appetite:                     | Good       | Variable                     | Picky   |                      |
| 8. Weaned from bottle/breast     | Yes        | No                           |         |                      |

Does your child have any problems with the following?

- |                     |     |    |                |     |    |
|---------------------|-----|----|----------------|-----|----|
| 1. Spitting Up      | Yes | No | 4. Sleep       | Yes | No |
| 2. Excessive Crying | Yes | No | 5. Stuffy Nose | Yes | No |
| 3. Constipation     | Yes | No | 6. Diaper Rash | Yes | No |

Do you have any concerns about your child's hearing or vision?

- Yes \_\_\_\_\_ No \_\_\_\_\_ Specify: \_\_\_\_\_

Lead Screening (please answer for ages 6 months, 9 months, 12 months, and 18 months)

- |   |     |    |
|---|-----|----|
| 1. Does your child live in or regularly visit a house built before 1950?                                      | Yes | No |
| 2. Does your child live in or regularly visit a house built before 1978 with recent renovations?              | Yes | No |
| 3. Does your child have a sibling or playmates that have or have had lead poisoning?                          | Yes | No |
| 4. Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking? | Yes | No |

Has there been any foreign travel in the last 60 days or international adoption? Yes \_\_\_\_\_ No \_\_\_\_\_

Has there been any exposure to smoking? Yes \_\_\_\_\_ No \_\_\_\_\_ Who: \_\_\_\_\_

Immunizations

- |   |     |    |
|---|-----|----|
| 1. Previous reaction to immunizations                     | Yes | No |
| 2. Have family members been immunized (mom, dad, sibling) | Yes | No |
| 3. History of chickenpox in child being seen              | Yes | No |
| 4. Serious illness at home or relatives (cancer)          | Yes | No |
| 5. Allergic to eggs, gelatin, Neomycin, yeast             | Yes | No |

Please describe your social history.

- |                      |                      |
|----------------------|----------------------|
| 1. Race: _____       | 4. Ethnicity: _____  |
| 2. Language: _____   | 5. # Siblings: _____ |
| 3. Lives With: _____ |                      |

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes \_\_\_\_\_ No \_\_\_\_\_ Specify: \_\_\_\_\_

Have there been any changes in your child's medical needs?

- |  |       |    |                |
|--|-------|----|----------------|
| 1. New problems or illness   | Yes   | No | Specify: _____ |
| 2. Please list current medications (prescription and over-the-counter) | _____ |    |                |

