6 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 ever look cross-eyed?	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
5 Has your baby had any problems with shots or immunizations?	NO	YES
6 Does your baby receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?	NO	YES

Feeding/Nutrition

7 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?			
8 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?			
b How many ounces of formula total each day?			
c Which formula are you feeding your baby?			
9 Are you giving your baby any solid foods?	YES	NO	
10 Do you give your baby any vitamins or supplements?	YES	NO	

Oral Health

11 Does your child sleep with a bottle?	NO	YES
12 Does your baby wake at night to eat?	NO	YES
13 Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your baby's teeth and gums?	YES	NO
14 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

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

Sleep

17 Does your baby sleep at least 6 to 8 hours without waking up at night?	YES	NO
18 Does your baby fall asleep on his/her own?	YES	NO
19 Do you have a bedtime routine?	YES	NO

Social Stressors

20 Has either parent been feeling down, depressed, or hopeless?	NO	YES	
21 Has either parent had little interest or pleasure in doing things they used to enjoy?	NO	YES	
22 Do you feel that you receive the support you need?	YES	NO	
23 Have there been any major changes or stresses in your family recently?	NO	YES	
24 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
25 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
26 Do you have any worries or concerns about childcare?	NO	YES	
27 Do you Ever feel angry or frustrated with your baby?	NO	YES	

Development
(If you are completing the Ages and Stages questionnaire please skip this section)

28 Does your baby babble and imitate sounds?	YES	NO
29 Does your baby respond to his/her name?	YES	NO
30 Does your baby roll over both ways?	YES	NO
31 Does your baby make eye contact?	YES	NO
32 Does your baby reach for things?	YES	NO
33 Does your baby stay sitting up by himself/herself for a few seconds?	YES	NO
34 Do you read to your baby every day?	YES	NO
35 Do you play games like peek-a-boo or play music with your baby?	YES	NO
36 Is your baby starting to use a sippy cup?	YES	NO

Safety

37 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
38 Does your baby wear any jewelry (including necklaces)?	NO	YES
39 Do you hold or carry hot liquids around the baby?	NO	YES
40 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
41 Does anyone smoke or vape around your baby?	NO	YES
42 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO
43 Are you using a shade or sunscreen if your baby is in the sun more than 10 minutes?	YES	NO
44 Do you keep plastic bags and latex balloons away from your baby?	YES	NO
45 Is your water heater turned to below 120 degrees?	YES	NO
46 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO
47 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO
48 Does your baby use a seated infant walker?	NO	YES