

Baby's Name \_\_\_\_\_

Baby's Birth Date \_\_\_\_\_

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

**Review of Nutrition**

	<b>Yes</b>	<b>No</b>
Is your baby being breastfed exclusively?	( )	( )
Is your baby feeding well?	( )	( )
How often is your baby feeding?		
How long/How many ounces?		
Is your baby stooling comfortably?	( )	( )
If breastfed, is your baby getting a daily vitamin?	( )	( )

**Social Screening**

	<b>Yes</b>	<b>No</b>
What are your current child-care arrangements?		
Is your baby happy, without frequent periods of fussiness for no obvious reason?	( )	( )
Is your mood good overall?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Is your baby in a car seat in the backseat facing backwards when in the car?	( )	( )
Does your home have functional smoke detectors?	( )	( )

**Sleep**

	<b>Yes</b>	<b>No</b>
Does your baby sleep on her/his back/side?	( )	( )
Does your baby sleep in her/his own crib?	( )	( )

**Developmental Screening**

	<b>Yes</b>	<b>No</b>
Does your baby follow people or objects with her/his eyes past her/his midline?	( )	( )
Does your baby respond well to sounds?	( )	( )
Does your baby hold her/his head and shoulders up while on her/his stomach?	( )	( )
Does your baby smile when spoken to or in response to your smile?	( )	( )

Has your baby had any significant illnesses since the last time we saw you? If yes, please describe:

\_\_\_\_\_

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

\_\_\_\_\_

Current concerns not listed above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_