



Child Name: _____

Bright Futures Previsit Questionnaire 2 Month Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions. Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

How You Are Feeling	<input type="checkbox"/> Getting back to normal activities	<input type="checkbox"/> Feeling sad	<input type="checkbox"/> Your partner helping you take care of your home and baby
	<input type="checkbox"/> Help taking care of your baby	<input type="checkbox"/> Brothers and sisters getting along with your baby	<input type="checkbox"/> Taking time for yourself
	<input type="checkbox"/> Finding time alone with your partner		
Your Growing Baby	<input type="checkbox"/> How you are doing with your baby	<input type="checkbox"/> Where your baby sleeps	<input type="checkbox"/> How your baby sleeps
	<input type="checkbox"/> How to keep your baby safe while sleeping	<input type="checkbox"/> Tummy time for playtime with you	<input type="checkbox"/> Rolling over
	<input type="checkbox"/> Talking with your baby	<input type="checkbox"/> Calming your baby	<input type="checkbox"/> Daily routines
Your Baby and Family	<input type="checkbox"/> Leaving your baby when going to work or school	<input type="checkbox"/> Finding good child care	
Feeding Your Baby	<input type="checkbox"/> Feeding routine	<input type="checkbox"/> When to begin solid food	<input type="checkbox"/> Holding <input type="checkbox"/> Burping <input type="checkbox"/> Your child's weight
	<input type="checkbox"/> Knowing when your baby is hungry or full	<input type="checkbox"/> Help with breastfeeding	<input type="checkbox"/> Formula feeding
Safety	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> How to check hot water temperature	<input type="checkbox"/> Choking
	<input type="checkbox"/> Preventing falls from rolling over	<input type="checkbox"/> Bathtub safety	<input type="checkbox"/> Cigarette smoke

Questions About Your Baby

Have any of your baby's relatives developed new medical problems since your last visit? If yes, please describe: Yes No Unsure

Vision Do you have concerns about how your child sees? Yes No Unsure

Does your child have any special health care needs? No Yes, describe:

Other than your baby's birth, have there been any major changes in your family lately?

Move Job change Separation Divorce Death in the family Any other changes?

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things Not at all Several days More than half the days Nearly every day
- Feeling down, depressed, or hopeless Not at all Several days More than half the days Nearly every day

Adapted with permission from "Efficient Identification of Adults with Depression and Dementia," September 15, 2004, American Family Physician. Copyright © 2004 American Academy of Family Physicians. All Rights Reserved.

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? No Yes

Your Growing and Developing Baby

Do you have specific concerns about your baby's development, learning, or behavior? No Yes, describe:

Check off each of the tasks that your baby is able to do.

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Smiles | <input type="checkbox"/> Comforts self (brings hands to mouth) | <input type="checkbox"/> Moves both arms and legs together |
| <input type="checkbox"/> Coos | <input type="checkbox"/> Has different types of cries to show hunger or when tired | <input type="checkbox"/> Holds head up when held |
| <input type="checkbox"/> Looks at you | <input type="checkbox"/> Fusses if bored | <input type="checkbox"/> Pushes head up when lying on tummy |



American Academy of Pediatrics



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Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input type="checkbox"/> Hardly ever<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<input type="checkbox"/> Never |
|--|--|

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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