1 MONTH OLD

"Although I am very new, I already have feelings I can't control and need your help to feel calm again."

Patient Name: _____

Person Filling Out Form: _____

Relationship to Patient: _____

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CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

yes no Does your child take any medications (daily or as needed)? If so, please list: _____
yes no Has your child had any reactions to medications?
yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes no Does the child's main caretaker plan to return to work or school? If yes, when? _____
yes no Is your child in day care?
yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes no Has a parent or household member ever had a problem with alcohol or drug use?
yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

yes no Is your baby breastfeeding?
yes no Is your baby taking any vitamins?
yes no Does your baby take a bottle? If so, what and how much? _____

PREVENTIVE HEALTH

yes no Does your baby always sleep on their back?
yes no Does your child sleep with a bottle, blanket, or pillow in the crib?
yes no Does your child always ride in a rear facing car seat and in the backseat?
yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
yes no Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
yes no Have those alarms been checked in the past 12 months?
yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
yes no Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
yes no Was your child born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside the United States, Canada, Australia, New Zealand, or Western European countries?)
yes no Is your child enrolled in WIC?

On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes no Eyes (drainage)
yes no Latch or feeding
yes no Coughing, noisy or difficulty breathing, turning blue
yes no Vomiting
yes no Stooling (diarrhea, constipation, or blood in the stools)
How often does your child stool? _____
yes no Urination (change in frequency, or blood in the urine)
How many wet diapers per day? _____
yes no Extremities (feet, legs, arms, hands)
yes no Excessive crying

DEVELOPMENT (please check the things that your child is currently doing)

Gross motor	[ ] Moves arms & legs equally [ ] Lifts head [ ] Lifts chest
Social	[ ] Settles when fed or comforted [ ] Responds to parents' voice
Language	[ ] Startles to sound [ ] Turns to noise

Thank you for filling out this form.

Revised 6/2021

Edinburgh Postnatal Depression Scale[1] (EPDS)

Patient Name: _____

Caregiver Name: _____

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As you are pregnant or caring for a new 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
□ No, not very often
□ No, not at all

This would mean: "I have felt happy most of the time" during the past week
Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

5. I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

8. I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

9. I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

10. The thought of harming myself has occurred to me
    - □ Yes, quite often
    - □ Sometimes
    - □ Hardly ever
    - □ Never

Does Pediatrics Northwest have your consent to enter the screening results into your child's medical record?

□ Yes □ No

Administered/Reviewed by_____ Date_____