



SWYC:TM 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.

	Not Yet	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.

	Not 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

	Not 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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FAMILY QUESTIONS

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

	Yes	No						
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						
	Never true	Sometimes true	Often true					
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
6 In general, how would you describe your relationship with your spouse/partner?	No tension <input type="radio"/>	Some tension <input type="radio"/>	A lot of tension <input type="radio"/>	Not applicable <input type="radio"/>				
7 Do you and your partner work out arguments with:	No difficulty <input type="radio"/>	Some difficulty <input type="radio"/>	Great difficulty <input type="radio"/>	Not applicable <input type="radio"/>				
8 During the past week, how many days did you or other family members read to your child?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 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.

In the past seven days...

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

- 0 As much as I always could
 1 Not quite so much now
 2 Definitely not so much now
 3 Not at all

2 I have looked forward with enjoyment to things

- 0 As much as I ever did
 1 Rather less than I used to
 2 Definitely less than I used to
 3 Hardly at all

3* I have blamed myself unnecessarily when things went wrong

- 3 Yes, most of the time
 2 Yes, some of the time
 1 Not very often
 0 No, never

4 I have been anxious or worried for no good reason

- 0 No, not at all
 1 Hardly ever
 2 Yes, sometimes
 3 Yes, very often

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

- 3 Yes, quite a lot
 2 Yes, sometimes
 1 No, not much
 0 No, not at all

6* Things have been getting on top of me

- 3 Yes, most of the time I haven't been able to cope at all
 2 Yes, sometimes I haven't been coping as well as usual
 1 No, most of the time I have coped quite well
 0 No, I have been coping as well as ever

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

- 3 Yes, most of the time
 2 Yes, sometimes
 1 Not very often
 0 No, not at all

8* I have felt sad or miserable

- 3 Yes, most of the time
 2 Yes, quite often
 1 Not very often
 0 No, not at all

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

- 3 Yes, most of the time
 2 Yes, quite often
 1 Only occasionally
 0 No, never

10* The thought of harming myself has occurred to me

- 3 Yes, quite often
 2 Sometimes
 1 Hardly ever
 0 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).