



6 Month Questionnaire

5 months 0 days
through 6 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you put your baby on the floor, does she lean on her hands while sitting? <i>(If she already sits up straight without leaning on her hands, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

5. If you hold both hands just to balance your baby, does he support his own weight while standing?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

6. Does your baby get into a crawling position by getting up on her hands and knees?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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GROSS MOTOR TOTAL —

FINE MOTOR

1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

2. Does your baby reach for or grasp a toy using both hands at once?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? (If he already picks up a small object the size of a pea, mark "yes" for this item.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?



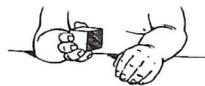
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? (If he already picks up the crumb or Cheerio, mark "yes" for this item.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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6. Does your baby pick up a small toy with only one hand?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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FINE MOTOR TOTAL —

PROBLEM SOLVING

1. When a toy is in front of your baby, does she reach for it with both hands?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

2. When your baby is on his back, does he turn his head to look for a toy when he drops it? (If he already picks it up, mark "yes" for this item.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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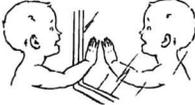
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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PROBLEM SOLVING (continued)

	YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your baby pass a toy back and forth from one hand to the other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your baby play by banging a toy up and down on the floor or table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	PROBLEM SOLVING TOTAL			—

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. While lying on her back, does your baby play by grabbing her foot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. When in front of a large mirror, does your baby reach out to pat the mirror?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. While your baby is on his back, does he put his foot in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	PERSONAL-SOCIAL TOTAL			—

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. When you help your baby stand, are his feet flat on the surface most of the time?
If no, explain:

YES

NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

YES

NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

5. Do you have concerns about your baby's vision? If yes, explain:

YES

NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO

Baby Pediatric Symptom Checklist (6 months)

Patient Name: _____ DOB/FDN: _____ Date: _____
 Name of person answering this form: _____ Relation to patient: _____
 Nombre de la persona llenando esta forma: _____ Relación al paciente: _____

<i>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./ Algunas veces todos los niños lloran, gruñen o se quejan, tienen problemas al dormir o tienen problemas cuando llegan a lugares nuevos. Comparado a la mayoría de los niños/as de esta edad, usted diría que su niño hace estas cosas igual, un poco más o mucho más que otros niños de su misma edad?</i>	Not at all/ Igual (0)	Some-what/ Un poco mas (1)	Very Much/ Mucho mas (2)
1. Does your child have a hard time being with new people? ¿Su niño/a tiene dificultad al estar con personas desconocidas?			
2. Does your child have a hard time in new places? ¿Su niño/a tiene dificultad al estar en lugares nuevos?			
3. Does your child have a hard time with change? ¿Su niño/a tiene dificultad con los cambios?			
4. Does your child mind being held by other people? ¿A su niño/a le molesta que lo carguen otras personas?			
		Total	/3
5. Does your child cry a lot? ¿Su niño/a llora mucho?			
6. Does your child have a hard time calming down? ¿Su niño/a tiene dificultad para calmarse?			
7. Is your child fussy or irritable? ¿Su niño/a se enoja fácilmente o se irrita?			
8. Is it hard to comfort your child? ¿Su niño/a es difícil de consolar?			
		Total	/3
9. Is it hard to keep your child on a schedule or routine? ¿Es difícil mantener a su niño/a en un horario o una rutina establecida?			
10. Is it hard to put your child to sleep? ¿Es difícil poner a su niño/a a dormir?			
11. Is it hard to get enough sleep because of your child? ¿Es difícil para usted dormir lo suficiente debido a su niño/a?			
12. Does your child have trouble staying asleep? ¿Su niño/a tiene dificultad para mantenerse dormido?			
		Total	/3
Reviewed by: _____			

Childhood Lead Assessment Questionnaire Cuestionario de evaluación infantil de riesgo por el Plomo	YES Sí	NO No	Un- sure No se
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? ¿Su hijo (a) es elegible para inscribirse en Medicaid, Head Start, All Kids o WIC?			
2. Does this child have a sibling with a blood level of 10mcg/dl or higher? ¿Su hijo(a) tiene un hermano(a) con nivel de plomo en la sangre de 10mcg/dl o mas alto?			
3. Does this child live in regularly visit a home built before 1978? ¿Su hijo(a) vive o visita regularmente una casa que ya haya sido construida antes de 1978?			
4. In the past year has this child been exposed to repairs, repainting, or renovation of a home built before 1978? ¿Desde el año pasado, ha sido expuesto su hijo/a a reparaciones, pintura o remodelaciones de la casa construida antes de 1978?			
5. Is this child a refugee or an adoptee from any foreign country? ¿Su hijo(a) ha sido exilado o ha sido adoptado de algun país extranjero?			
6. Has this child ever been to Mexico, Central or South America, Asian Countries, or any country where exposure to lead from certain items could have occurred (cosmetics, home remedies, folk medicines, or glazed pottery)? ¿Su hijo(a) ha sido a los siguientes países: Mexico, America Central, o del sur, Asia, China o India, o cualquier país donde pudo haber estado expuesto a objetos que contienen plomo? (por ejemplo, cosméticos, remedios caseros, medicinas tradicionales o cerámica vidriada)?			
7. Does this child live with someone who has a job or a hobby that may involve lead (jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, leaded glass, lead shots, bullets or lead fishing sinkers)? ¿Vive su hijo(a) con alguna persona que tenga un trabajo o un pasatiempo que incluya plomo (joyas, renovación o construcción de puentes, plomería, recabados de muebles o un trabajo con baterías o radiadores de automóviles, soldadores de plomo, vidrio de plomo, balas)?			
8. At any time has this Child lived near a factory where lead is used? ¿En algun momento su hijo(a) ha vivido cerca de una fábrica donde se use plomo?			
9. Does this child reside in a high-risk zip code? (High-risk zip codes- LAKE: 60040, MCHENRY: 60034, All Chicago zip codes) ¿Su hijo(a) vive en un código postal de alto riesgo? (Código de alto riesgo LAKE- 60040, MCHENRY- 60034, Todos los códigos postal de Chicago)			

Mother's Name/Nombre de Mama: _____

Edinburgh Postnatal Depression Scale – for 6 months old and younger/ para 6 meses y menos	
<p>As you have recently had a baby, we would like to know how you are feeling. Please <u>UNDERLINE</u> which comes closest to how you have felt. <u>IN THE PAST 7 DAYS</u>, not just how you feel today. Como usted ha poco tuvo un bebe, nos gustaria saber como se ha estado sintiendo. Por favor haga un circulo alrededor de la respuesta que mas se acerca a como se ha sentido en los ultimos.</p>	
<u>In the Past 7 Days:</u>	<u>En los ultimos 7 dias:</u>
<p>1. I have been able to laugh and see the funny side of things as much as I always could. 0 – As much as I always could 1 – Not quite so much now 2 – Definitely not so much now 3 – Not at all</p> <p>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</p> <p>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</p> <p>4. I have been anxious or worried for no good reasons. 0 – No, not at all. 1 – Hardly, ever 2 – Yes, sometimes 3 – Yes, very often</p> <p>5. I have felt scared or panicky for no very good reason. 3 – Yes, quite a lot 2 – Yes, sometimes 1 – No, not much 0 – No, not at all</p> <p>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</p> <p>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</p> <p>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</p> <p>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, not at all</p> <p>10. The thought of harming myself has occurred to me. 3 – Yes, quite often 2 – Sometimes 1 – Hardly ever 0 – Never</p>	<p>1. He podido reír y ver el lado bueno de las cosas: 0 – Tanto como siempre he podido hacerlo 1 – No tanto ahora 2 – Sin duda, mucho menos ahora 3 – No, en absolute</p> <p>2. He mirado al futuro con placer para hacer cosas: 0 – Tanto como siempre 1 – Algo menos de lo que solía hacerlo 2 – Definitivamente menos de lo que solía hacerlo 3 – Prácticamente nunca</p> <p>3. Me he culpado sin necesidad cuando las cosas marchaban mal: 3 – Sí, casi siempre 2 – Sí, algunas veces 1 – No muy a menudo 0 – No, nunca</p> <p>4. He estado ansiosa y preocupada sin motivo alguno: 0 – No, en absolute 1 – Casi nada 2 – Sí, a veces 3 – Sí, muy a menudo</p> <p>5. He sentido miedo o pánico sin motivo alguno: 3 – Sí, bastante 2 – Sí, a veces 1 – No, no mucho 0 – No, en absolute</p> <p>6. Las cosas me oprimen o agobian: 3 – Sí, la mayor parte del tiempo no he podido sobrellevarlas 2 – Sí, a veces no he podido sobrellevarlas de la manera 1 – No, la mayoría de las veces he podido sobrellevarlas bastante bien 0 – No, he podido sobrellevarlas tan bien como lo hecho siempre</p> <p>7. Me he sentido tan infeliz, que he tenido dificultad para dormir: 3 – Sí, casi siempre 2 – Sí, a veces 1 – No muy a menudo 0 – No, en absolute</p> <p>8. Me he sentido triste y desgraciada: 3 – Sí, casi siempre 2 – Sí, bastante a menudo 1 – No muy a menudo 0 – No, en absolute</p> <p>9. Me he sentido tan infeliz que he estado llorando: 3 – Sí, casi siempre 2 – Sí, bastante a menudo 1 – Ocasionalmente 0 – No, nunca</p> <p>10. He pensado en hacerme daño: 3 – Sí, bastante a menudo 2 – A veces 1 – Casi nunca 0 – No, nunca</p>
Reviewed by: _____	