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?	◯	◯	◯	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	◯	◯	◯	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	◯	◯	◯	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	◯	◯	◯	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	◯	◯	◯	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	◯	◯	◯	___

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?	◯	◯	◯	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	◯	◯	◯	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	◯	◯	◯	___
4. When you put your baby on the floor, does she lean on her hands while sitting? *(If she already sits up straight without leaning on her hands, mark "yes" for this item.)* 	◯	◯	◯	___

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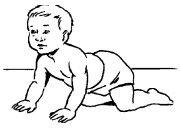
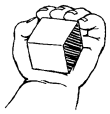
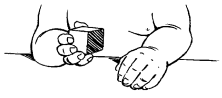
GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. If you hold both hands just to balance your baby, does he support his own weight while standing? 	○	○	○	___
6. Does your baby get into a crawling position by getting up on her hands and knees? 	○	○	○	___
		GROSS MOTOR TOTAL		___

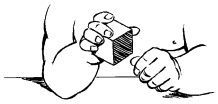
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	○	○	○	___
2. Does your baby reach for or grasp a toy using both hands at once?	○	○	○	___
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.)* 	○	○	○	___
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it? 	○	○	○	___
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.)* 	○	○	○	___
6. Does your baby pick up a small toy with only one hand? 	○	○	○	___
		FINE MOTOR TOTAL		___

PROBLEM SOLVING

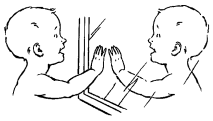
	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
				___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth? 	○	○	○	___
5. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
6. Does your baby play by banging a toy up and down on the floor or table? 	○	○	○	___

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? 	○	○	○	___
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.)*	○	○	○	___
3. While lying on her back, does your baby play by grabbing her foot? 	○	○	○	___
4. When in front of a large mirror, does your baby reach out to pat the mirror? 	○	○	○	___
5. While your baby is on his back, does he put his foot in his mouth? 	○	○	○	___
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.)*	○	○	○	___

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

Lead Exposure Risk Assessment Questionnaire for Children

In addition to the required testing of all children for lead with a blood lead test at one year of age and again at age two, assessment of risk for lead exposure should be done at each well-child visit or at least annually for each child six months to six years of age. The questions below serve as a risk assessment tool based on currently accepted public health guidelines. Children found to be at risk for lead exposure should receive a blood lead test whenever such risk is identified.

Questions	Answer	
	Yes	No
1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling? **Note**: This could include a day care center, preschool, and the home of a babysitter or a relative.		
2. Has your family/child ever lived outside the United States or recently arrived from a foreign country?		
3. Does your child have a brother/sister, housemate/playmate being followed or treated for lead poisoning?		
4. Does your child frequently put things in his/her mouth such as toys, jewelry, or keys? Does your child eat non-food items (pica)? **Note**: This may include toys or jewelry products that have been recalled by the Consumer Products Safety Commission (CPSC) due to unsafe lead levels: www.nyhealth.gov/environmental/lead/recalls		
5. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? **Note**: Jobs include house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.		
6. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? **Note**: May need to alert parent/caregiver if such an industry is local.		
7. Does your family use products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter? **Note:** Lead has been found in traditional medicines such as Ayurvedic medicine, liga, greta, azarcon, litargirio, and in cosmetics such as kohl, surma, and sindoor. Lead exposure risk is higher with old, imported, painted, cracked or chipped china, and in low-fired and terra cotta pottery, often made in Latin America and the Middle East.		

If the answer to any of the above questions is YES, then the child is considered to be at risk for lead exposure and should receive a blood lead test.

- Ask any additional questions that may be specific to a particular community (or population) e.g. high risk zip code, refugee child recently arrived in the United States, children with behavioral and/or developmental disabilities, children who receive Medicaid or children entering foster care.
- Ask if any of the above conditions are expected to change in the future (e.g. house remodeling).
- Tailor appropriate anticipatory guidance to the child and family.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

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
- □ 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

Administered/Reviewed by _____ Date _____

[1]Source: 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 .

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