



# Bright Futures Parent Handout 2 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

## How You Are Feeling

- Taking care of yourself gives you the energy to care for your baby. Remember to go for your postpartum checkup.
- Find ways to spend time alone with your partner.
- Keep in touch with family and friends.
- Give small but safe ways for your other children to help with the baby, such as bringing things you need or holding the baby's hand.
- Spend special time with each child reading, talking, or doing things together.

## Your Growing Baby

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Put your baby to sleep on her back.
  - In a crib, in your room, not in your bed.
  - In a crib that meets current safety standards, with no drop-side rail and slats no more than 2 3/8 inches apart. Find more information on the Consumer Product Safety Commission Web site at [www.cpsc.gov](http://www.cpsc.gov).
- If your crib has a drop-side rail, keep it up and locked at all times. Contact the crib company to see if there is a device to keep the drop-side rail from falling down.
- Keep soft objects and loose bedding such as comforters, pillows, bumper pads, and toys out of the crib.
  - Give your baby a pacifier if she wants it.
- Hold, talk, cuddle, read, sing, and play often with your baby. This helps build trust between you and your baby.
- Tummy time—put your baby on her tummy when awake and you are there to watch.
- Learn what things your baby does and does not like.

BEHAVIOR

- Notice what helps to calm your baby such as a pacifier, fingers or thumb, or stroking, talking, rocking, or going for walks.

## Safety

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your seat belt and never drive after using alcohol or drugs.
- Keep your car and home smoke-free.
- Keep plastic bags, balloons, and other small objects, especially small toys from other children, away from your baby.
- Your baby can roll over, so keep a hand on your baby when dressing or changing him.
- Set the water heater so the temperature at the faucet is at or below 120°F.
- Never leave your baby alone in bathwater, even in a bath seat or ring.

SAFETY

## Your Baby and Family

- Start planning for when you may go back to work or school.
- Find clean, safe, and loving child care for your baby.
- Ask us for help to find things your family needs, including child care.
- Know that it is normal to feel sad leaving your baby or upset about your baby going to child care.

INFANT-FAMILY SYNCHRONY

## Feeding Your Baby

- Feed only breast milk or iron-fortified formula in the first 4–6 months.
- Avoid feeding your baby solid foods, juice, and water until about 6 months.
- Feed your baby when your baby is hungry.

NUTRITIONAL ADEQUACY

- Feed your baby when you see signs of hunger.
  - Putting hand to mouth
  - Sucking, rooting, and fussing
- End feeding when you see signs your baby is full.
  - Turning away
  - Closing the mouth
  - Relaxed arms and hands
- Burp your baby during natural feeding breaks.

## If Breastfeeding

- Feed your baby 8 or more times each day.
- Plan for pumping and storing breast milk. Let us know if you need help.

## If Formula Feeding

- Feed your baby 6–8 times each day.
- Make sure to prepare, heat, and store the formula safely. If you need help, ask us.
- Hold your baby so you can look at each other.
- Do not prop the bottle.

NUTRITIONAL ADEQUACY

## What to Expect at Your Baby's 4 Month Visit

### We will talk about

- Your baby and family
- Feeding your baby
- Sleep and crib safety
- Calming your baby
- Playtime with your baby
- Caring for your baby and yourself
- Keeping your home safe for your baby
- Healthy teeth

Poison Help: 1-800-222-1222

Child safety seat inspection:  
1-866-SEATCHECK; [seatcheck.org](http://seatcheck.org)



American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Name: \_\_\_\_\_

FMP and Sponsor Last Four: \_\_\_\_\_ / \_\_\_\_\_

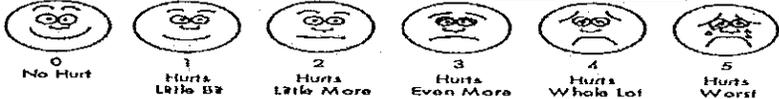
Date: \_\_\_\_\_

(Patient Label)

If this is the **FIRST** time you are filling in this form, please complete **ALL** areas.  
If you have **ALREADY** completed it, please complete **SHADED** areas **ONLY**.

1  **No Allergies** Please list any allergies you have (drug, food, latex) \_\_\_\_\_

**Clinic Use Only**

BP	/	HT	Visual Acuity: R 20/____ L 20/____ Both 20/____
HR		WT	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____
RR		HC	
TEMP		SpO2	

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates) (Circle all that apply)	Family History—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)	Medicines (PLEASE INCLUDE DOSAGE)
NO Medical Conditions  Asthma Diabetes Hayfever/Allergies Other:	NO History of Surgeries  Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other:	Birth Defects Deafness before Age 5 Kidney Disease Post Partum Depression Early or Sudden Death to include SIDS Heart attack before age 50 High Blood Pressure High Cholesterol Hypertrophic Cardiomyopathy Long QT syndrome Arrhythmias Diabetes Mental Illness Alcohol or Substance Abuse Genetic or Metabolic Disease Other:	Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter  <input type="checkbox"/> Infant Multivitamin 1 ml per day

**BIRTH HISTORY-Complete for AGES NEWBORN TO 2 YEARS**

Place of Birth: \_\_\_\_\_  
 Birth weight? \_\_\_\_\_ # weeks pregnant at delivery? \_\_\_\_\_  
 Prenatal complications  No  Yes describe: \_\_\_\_\_  
 Group B Strep. (GBS)  Positive  Negative  Don't Know  
 Type of Delivery (check all that apply):  
 Vaginal  Forceps  Vacuum-assisted  C-section  Breech  
 Complications at birth?  
 Jaundice \*  Yes  No Phototherapy \*  Yes  No Hip Click/Clunk \*  Yes  No  
 Other: \_\_\_\_\_  
 Did your child receive the Hepatitis B vaccine at birth?  Yes  No  Unsure

**Newborn Metabolic Screen Submitted:**

Yes  No  Don't Know  
 Repeated  
**Baby's Hearing Screen:**  
 Passed Bilateral  
 Repeat Needed  
 Don't Know

Clinic Use Only - For Newborns-2 weeks  
 Complete Risk assessment for Jaundice  
 (Bill and Blood Type)

Source of Medical Information:  Mother  Father  Patient  Other:  
 Any Hospitalizations, specialty care, or ER visits since your last appointment?  No  Yes:  
 Would you say your child's Overall Feeling of health is?  Excellent  Very Good  Good  Fair  Poor  
 Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?  Yes  No  Decline  
 Are your child's immunizations up to date?  Yes  Unsure  No

Does your child have a chronic medical or behavioral health problem, and/or physical disability?  No  Yes  
 Is frequent follow-up support required for the above issues?  No  Yes  
 Does your child require early interventions or special education services?  No  Yes  
 Is your child enrolled in the Exceptional Family Member Program?  No  Yes

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

Is your child  In Day-Care  
 Does anyone in the family smoke or is your child exposed to secondhand smoke?  No  Yes  
 Who does the Child Live With?  Parents  Mother  Father  Other: \_\_\_\_\_  
 Is Sponsor currently deployed:  No  Yes  
 Is this visit deployment related:  No  Yes  
 Does your child ride in a car with a car seat?  Yes  No

**Tuberculosis Screening - Complete at 1, 6, 12, and 18 month Well Child Visit**  
 Yes  No  Unsure Has a family member or contact had tuberculosis?  
 Yes  No  Unsure Has a family member had a positive tuberculin skin test?  
 Yes  No  Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, or Western Europe)?  
 Yes  No  Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

**Lead Screening - Complete at 6, 9, 12, and 18 Month Well Child Visit**  
 Yes  No  Unsure Does your child have a sibling or playmate with Hx of lead poisoning?  
 Yes  No  Unsure Does your child live in or regularly visit a house or child care facility built before 1950?  
 Yes  No  Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

What is your preferred method for learning:  Verbal  Written  Visual  Hands-On  Other: \_\_\_\_\_  
 Yes  No - Do you or your child have learning/readiness needs?  
 Yes  No - Are there cultural or religious considerations that affect your child's healthcare?  
 Yes  No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?  
**\*\*PLEASE PROVIDE A GOOD CONTACT NUMBER: \_\_\_\_\_**

Breastfeeding?  Yes  No How often? \_\_\_\_\_ Minutes per breast? \_\_\_\_\_ Concerns? \_\_\_\_\_  
 Bottle feeding?  Yes  No Brand? \_\_\_\_\_ Ounces per feed? \_\_\_\_\_ How often? \_\_\_\_\_  
 Number of wet diapers per day? \_\_\_\_\_ Stools per day? \_\_\_\_\_  
 Circle if you have any concerns about the following (circle all that apply): Bowel movements / Constipation / Sleep problems

If Edinburgh Postpartum Depression Screen (EPDS) not attached.  
 Mother please complete below questionnaire at 1 week, 2 and 4 month Well Child visits.

Over the last 2 weeks, how often have you been bothered by any of the following?  
 Little interest or pleasure in doing things?  Not at all  Several days  More than half the days  Nearly every day  
 Feeling depressed or hopeless?  Not at all  Several days  More than half the days  Nearly every day

----- (This section NOT for patient use) -----

**Treatments orders for this visit - Ensure Patients Name and last four on Front of Document:**

<input type="checkbox"/> Flu Swab	<input type="checkbox"/> Ear Irrigation	<input type="checkbox"/> CBC	<input type="checkbox"/> Chol Panel	<input type="checkbox"/> Billirubin (T/D)	<input type="checkbox"/> CXR
<input type="checkbox"/> RSV Swab	Left --- Right	<input type="checkbox"/> UA	<input type="checkbox"/> HbA1c	<input type="checkbox"/> TsBill	<input type="checkbox"/> EKG
<input type="checkbox"/> Strep Screen/TCx	<input type="checkbox"/> Saline Bulb Suction	<input type="checkbox"/> CRP/ESR	<input type="checkbox"/> TSH, T4	<input type="checkbox"/> Monospot	
<input type="checkbox"/> Tussin Swab	<input type="checkbox"/> Motrin (PO) _____ mg	<input type="checkbox"/> BMP	<input type="checkbox"/> Iron Profile	<input type="checkbox"/> EBV Titers	
<input type="checkbox"/> Dex	<input type="checkbox"/> Tylenol (PO) _____ mg	<input type="checkbox"/> CMP	<input type="checkbox"/> Lead		
<input type="checkbox"/> EVALUATE FOR VACCINE UPDATE <input type="checkbox"/> PPD <input type="checkbox"/> Other _____					
<input type="checkbox"/> Immunizations - 2 Month - Pediarix (DTaP-IPV-HepB), Hib, PCV-13, Rotateq					

Well Child Developmental Screenings

1 Week (3-5 days)	1 MONTH	2 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Eats well	<input type="checkbox"/> If upset, able to calm	<input type="checkbox"/> Lifts head and begins to push up when prone
<input type="checkbox"/> Follows your face	<input type="checkbox"/> Has started to smile	<input type="checkbox"/> Holds head erect for short period (when held upright)
<input type="checkbox"/> Turns and calms to your voice	<input type="checkbox"/> Recognizes voice of parents	<input type="checkbox"/> Diminished newborn reflexes
<input type="checkbox"/> Can suck, swallow and breathe easy	<input type="checkbox"/> Follows parents with eyes	<input type="checkbox"/> Symmetrical movements
	<input type="checkbox"/> Able to lift head when on tummy	<input type="checkbox"/> Indicates boredom when no activity change
		<input type="checkbox"/> Coos
		<input type="checkbox"/> Different crying for different needs
		<input type="checkbox"/> Smiles
		<input type="checkbox"/> Looks for parents
		<input type="checkbox"/> Self-comfort
4 MONTH	6 MONTH	9 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)***
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Pushes chest to elbows	<input type="checkbox"/> Sits briefly, leaning forward	<input type="checkbox"/> Sits well
<input type="checkbox"/> Good Head control	<input type="checkbox"/> Rolls over	<input type="checkbox"/> Crawls
<input type="checkbox"/> Symmetry in movements	<input type="checkbox"/> Uses visual exploration	<input type="checkbox"/> Pulls to feet with support
<input type="checkbox"/> Begins to roll and reach for objects	<input type="checkbox"/> Beginning to use oral exploration	<input type="checkbox"/> Peekaboo
<input type="checkbox"/> Responds to affection	<input type="checkbox"/> Uses a string of vowels (ah, eh, oh)	<input type="checkbox"/> Objects permanence
<input type="checkbox"/> Indicates pleasure or displeasure	<input type="checkbox"/> Beginning to recognize own name	<input type="checkbox"/> Looks at book
<input type="checkbox"/> Spontaneous expressive babbling	<input type="checkbox"/> Enjoys vocal turn-taking	<input type="checkbox"/> Imitates sounds
<input type="checkbox"/> Social smile	<input type="checkbox"/> Shows pleasure from interaction with parents or others	<input type="checkbox"/> Points out objects
<input type="checkbox"/> Elicits social interactions		<input type="checkbox"/> Stranger anxiety
<input type="checkbox"/> Smiles spontaneously		<input type="checkbox"/> Seeks parent for comfort
<input type="checkbox"/> Can calm down on own		
12 MONTH	15 MONTH	18 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)***
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Waves bye-bye	<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house
<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house	<input type="checkbox"/> Laughs in response to others
<input type="checkbox"/> Cries when you leave	<input type="checkbox"/> Listens to a story	<input type="checkbox"/> Speaks 6 words
<input type="checkbox"/> Plays Peekaboo	<input type="checkbox"/> Says 2 to 3 words	<input type="checkbox"/> Knows names of favorite books
<input type="checkbox"/> Hands you a book to read	<input type="checkbox"/> Scribbles	<input type="checkbox"/> Points to 1 body part
<input type="checkbox"/> Speaks 1-2 words	<input type="checkbox"/> Follows simple commands	<input type="checkbox"/> Stacks 2 small blocks
<input type="checkbox"/> Babbles	<input type="checkbox"/> Bends down without falling	<input type="checkbox"/> Runs
<input type="checkbox"/> Tries to make the same sounds you do	<input type="checkbox"/> Walks well	<input type="checkbox"/> Walk up steps
<input type="checkbox"/> Looks at things you are looking at	<input type="checkbox"/> Puts blocks in a cup	<input type="checkbox"/> Uses spoon and cup without spilling most of the time
<input type="checkbox"/> Follows simple directions	<input type="checkbox"/> Puts block in a cup	
<input type="checkbox"/> Bangs toys together	<input type="checkbox"/> Drinks from cup with very little spilling	

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

AHLTA was not accessible during this patient visit. Reviewed note & agree \_\_\_\_ *(Provider Initial)*

VISIT FOR:  Acute Well Child Visit     3-5 day/1 week     1 Month     2 Months     4 Months  
 6 Months     9 Months     12 Months     15 Months     18 Months

HPI:

ROS: Check only symptoms that may apply to today's visit.

<input type="checkbox"/> Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Poor Weight Gain
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hearing Concerns
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Earache	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Pulling at the Ear(s)	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Snoring
<input type="checkbox"/> Eyes Discharge	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Rash	<input type="checkbox"/> Excessive Thirst

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	<b>General:</b>	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	<b>Head/Neck:</b>	<input type="checkbox"/> NCAT/AFOF/neck supple	<input type="checkbox"/>
<input type="checkbox"/>	<b>Eyes:</b>	<input type="checkbox"/> EOMI, RR X2, NI corneal reflex <input type="checkbox"/> no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	<b>R ear:</b>	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>L ear:</b>	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>Nose:</b>	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	<b>Oropharynx:</b>	<input type="checkbox"/> Pink, moist, no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	<b>Lungs:</b>	<input type="checkbox"/> CTAB, no retractions, NI WOB	<input type="checkbox"/>
<input type="checkbox"/>	<b>CV:</b>	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	<b>Abd:</b>	<input type="checkbox"/> Soft, NT, no HSM, no masses, ni BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	<b>Ext/Spine:</b>	<input type="checkbox"/> NL, FROM, nontender, no edema, <input type="checkbox"/> no sacral dimple	<input type="checkbox"/> Sacral Dimple
<input type="checkbox"/>	<b>Skin:</b>	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/> Jaundice
<input type="checkbox"/>	<b>Hips:</b>	<input type="checkbox"/> Full ROM, <input type="checkbox"/> Neg Barlow <input type="checkbox"/> Neg Ortolani	<input type="checkbox"/> Hip click <input type="checkbox"/> Hip clunk
<input type="checkbox"/>	<b>Neuro:</b>	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	<b>Genitalia:</b>	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down B/L	<input type="checkbox"/>
<input type="checkbox"/>	<b>Other findings:</b>	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS:  Hip U/S     Spine U/S

A/P :     Well baby: normal growth & development for age  
 400 IU Vitamin D supplement/day     Infant Multivitamin 1 ml per day     Triple paste to diaper area Q diaper change

F/U: at next well child visit at \_\_\_\_ months, or sooner if parental concerns  
 Patient and/or parent verbalizes understanding of treatment and plan  
 Anticipatory guidance/Prevention handout provided

# Edinburgh Postnatal Depression Scale<sup>1</sup> (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      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:

- 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 \_\_\_\_\_

<sup>1</sup>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 .

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

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# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Postpartum depression is the most common complication of childbearing.<sup>2</sup> The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <[www.4women.gov](http://www.4women.gov)> and from groups such as Postpartum Support International <[www.chss.iup.edu/postpartum](http://www.chss.iup.edu/postpartum)> and Depression after Delivery <[www.depressionafterdelivery.com](http://www.depressionafterdelivery.com)>.

## SCORING

### QUESTIONS 1, 2, & 4 (without an \*)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

### QUESTIONS 3, 5-10 (marked with an \*)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

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## Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

<sup>1</sup>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.

<sup>2</sup>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



# Ages & Stages Questionnaires®

## 2 Month Questionnaire

1 month 0 days through 2 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: \_\_\_\_\_

### Baby's information

Baby's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Baby's last name: \_\_\_\_\_

Baby's date of birth: \_\_\_\_\_ If baby was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_

Baby's gender:  Male  Female

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_ Relationship to baby:  Parent  Guardian  Teacher  Child care provider

Grandparent or other relative  Foster parent  Other: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Names of people assisting in questionnaire completion: \_\_\_\_\_

### Program Information

Baby ID #: \_\_\_\_\_ Age at administration in months and days: \_\_\_\_\_

Program ID #: \_\_\_\_\_ If premature, adjusted age in months and days: \_\_\_\_\_

Program name: \_\_\_\_\_

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:

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## COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After you have been out of sight, does your baby smile or get excited when she sees 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 he wave his arms and legs, wiggle, and squirm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she turn her head to the side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her back, does she kick her legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

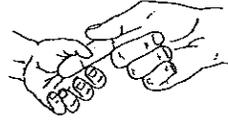
GROSS MOTOR TOTAL \_\_\_\_\_

**FINE MOTOR**

1. Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "yes.")

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

2. Does your baby grasp your finger if you touch the palm of her hand?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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3. When you put a toy in his hand, does your baby hold it in his hand briefly?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. Does your baby touch her face with her hands?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___*
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6. Does your baby grab or scratch at her clothes?

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

\*If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."

**PROBLEM SOLVING**

1. Does your baby look at objects that are 8-10 inches away?

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

2. When you move around, does your baby follow you with his eyes?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

PROBLEM SOLVING TOTAL

**PERSONAL-SOCIAL**

- |  | YES                   | SOMETIMES             | NOT YET               |     |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your baby sometimes try to suck, even when she's not feeding?                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby cry when he is hungry, wet, tired, or wants to be held?                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby smile at you?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you smile at your baby, does she smile back?                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby watch his hands?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When your baby sees the breast or bottle, does she seem to know she is about to be fed? | <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. Did your baby pass the newborn hearing screening test? If no, explain:  YES  NO

2. Does your baby move both hands and both legs equally well? If no, explain:  YES  NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain:  YES  NO

**OVERALL** (continued)

4. Has your baby had any medical problems? If yes, explain:

 YES NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain:

 YES NO

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

 YES NO



# 2 Month ASQ-3 Information Summary

1 months 0 days through  
2 months 30 days

Baby's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_

Baby's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Administering program/provider: \_\_\_\_\_ Was age adjusted for prematurity when selecting questionnaire?  Yes  No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	22.77		<input type="radio"/>												
Gross Motor	41.84		<input type="radio"/>												
Fine Motor	30.16		<input type="radio"/>												
Problem Solving	24.62		<input type="radio"/>												
Personal-Social	33.71		<input type="radio"/>												

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |  |     |           |  |     |    |
|--|-----|-----------|--|-----|----|
| 1. Passed newborn hearing screening test?<br>Comments:       | Yes | <b>NO</b> | 4. Any medical problems?<br>Comments:    | YES | No |
| 2. Moves both hands and both legs equally well?<br>Comments: | Yes | <b>NO</b> | 5. Concerns about behavior?<br>Comments: | YES | No |
| 3. Family history of hearing impairment?<br>Comments:        | YES | No        | 6. Other concerns?<br>Comments:          | YES | No |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the  area, it is above the cutoff, and the baby's development appears to be on schedule.  
If the baby's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.  
If the baby's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in \_\_\_\_\_ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): \_\_\_\_\_

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



## Questions about your child's development?

### **Educational & Developmental Intervention Services (EDIS)**

is a program for infants and toddlers (birth to 36 months) who have:

- medical conditions which may affect development  
(such as complications of prematurity, hearing or visual impairment)
- developmental delay (for example, not walking or talking as expected)  
or atypical development
- genetic conditions

**Educational & Developmental Intervention Services** provides:

- in-home services
- basic services are free to eligible children:
  - \* developmental evaluation (includes physical, communication, problem-solving, self-help, and social-emotional skills)
  - \* in-home training for parents on encouraging child's development
  - \* service coordination (helps parents access other services)

### **Parents can refer their children!**

*To make a referral, call:*

(for families living on base:)

**Educational & Developmental  
Intervention Services**  
Location: NH200 Annex  
Naval Hospital Camp Lejeune  
Mailing Address:  
EDIS  
100 Brewster Blvd  
Camp Lejeune, NC 28547  
910 450 4127

(for families living off base:)

**Children's Developmental Services Agency**  
2842 Neuse Blvd  
New Bern, NC 28562  
866 KIDS N NC (toll free)  
866 543 7662