SWYC™: 4 months

4 months, 0 days to 5 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
Holds head steady when being pulled up to a sitting position	○	○	○
Brings hands together	○	○	○
Laughs	○	○	○
Keeps head steady when held in a sitting position	○	○	○
Makes sounds like "ga," "ma," or "ba"	○	○	○
Looks when you call his or her name	○	○	○
Rolls over	○	○	○
Passes a toy from one hand to the other	○	○	○
Looks for you or another caregiver when upset	○	○	○
Holds two objects and bangs them together	○	○	○

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?	○	○	○
Does your child have a hard time in new places?	○	○	○
Does your child have a hard time with change?	○	○	○
Does your child mind being held by other people?	○	○	○
Does your child cry a lot?	○	○	○
Does your child have a hard time calming down?	○	○	○
Is your child fussy or irritable?	○	○	○
Is it hard to comfort your child?	○	○	○
Is it hard to keep your child on a schedule or routine?	○	○	○
Is it hard to put your child to sleep?	○	○	○
Is it hard to get enough sleep because of your child?	○	○	○
Does your child have trouble staying asleep?	○	○	○

PARENT'S CONCERNS

	Not at all	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

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?	◯	◯
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	◯	◯
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	◯	◯
4 Has a family member's drinking or drug use ever had a bad effect on your child?	◯	◯

	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.	◯	◯	◯

6 In general, how would you describe your relationship with your spouse/partner?	**No tension** ◯	**Some tension** ◯	**A lot of tension** ◯	**Not applicable** ◯
7 Do you and your partner work out arguments with:	**No difficulty** ◯	**Some difficulty** ◯	**Great difficulty** ◯	**Not applicable** ◯

8 During the past week, how many days did you or other family members read to your child?

*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

◯ 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 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