Northwest PRIMARY CARE

2 WEEKS - 1 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB: _____ Male ☐ Female ☐

Physician Signature: _____

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your baby?	◯ NO	◯ YES
Are they excessive spitting or vomiting?	◯ NO	◯ YES
Are they excessively crying (more than 3 hours/day)?	◯ NO	◯ YES
Do you have concerns about body movements?	◯ NO	◯ YES
Do they have severe nasal stuffiness?	◯ NO	◯ YES
Are you concerned about skin color or rash?	◯ NO	◯ YES
Did you know that a rectal temperature of 100.4 is a fever?	◯ YES	◯ NO
Could you take a rectal temperature if necessary?	◯ YES	◯ NO
Feeding/ Nutrition		
Is your child breast feeding well?	◯ YES	◯ NO
How often?		
For how long? (minutes)		
Is your child taking formula well?	◯ YES	◯ NO
How often?		
How many ounces?		
Which formula?		
Are you feeding your baby anything other than breast milk or formula?	◯ NO	◯ YES
Elimination		
Are they having problems with bowel movements (pooping)?	◯ NO	◯ YES
Are they urinating (peeing) well?	◯ YES	◯ NO
Sleep		
Do you have questions about sleep habits?	◯ NO	◯ YES
Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	◯ NO	◯ YES
If there are other children in the house, are they adjusting well to the newborn?	◯ YES	◯ NO
Are you having family stress?	◯ NO	◯ YES
Do you ever worry your family will go hungry?	◯ NO	◯ YES

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Name: _____ DOB:_____

Development		
Does your baby turn his/her head towards the direction of sound?	◯ **YES**	◯ **NO**
Does your baby follow parent with his/her eyes?	◯ **YES**	◯ **NO**
Does your baby recognize parents' voices?	◯ **YES**	◯ **NO**
Does your baby respond to your face or bright light?	◯ **YES**	◯ **NO**
Is your baby responsive to calming actions when upset?	◯ **YES**	◯ **NO**
Does your baby raise head slightly when on tummy?	◯ **YES**	◯ **NO**
Does your baby have tummy time while awake?	◯ **YES**	◯ **NO**
Safety		
Does your baby sleep on his/her back?	◯ **YES**	◯ **NO**
Does your baby sleep in a bassinet or crib and not parents' bed?	◯ **YES**	◯ **NO**
Do you always keep a hand on baby when placed above the floor?	◯ **YES**	◯ **NO**
Does your baby wear any jewelry including necklaces?	◯ **NO**	◯ **YES**
Does your baby ride in a rear facing safety seat, in the back seat?	◯ **YES**	◯ **NO**
Is your baby exposed to anyone who smokes?	◯ **NO**	◯ **YES**
Are there working smoke detectors in the home?	◯ **YES**	◯ **NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	◯ **NO**	◯ **YES**
Has a family member or contact had a positive TB skin test (PPD)?	◯ **NO**	◯ **YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	◯ **NO**	◯ **YES**
Has your baby traveled to a high-risk country for more than a week?	◯ **NO**	◯ **YES**