



## Six Month Well-Child Visit Pre-Appointment Paperwork

Please complete the following forms prior to your child's upcoming well-child visit. All forms are fillable PDFs that can be completed on your computer/smartphone, or you can print this packet and fill it in by hand.

If you are coming to our office, please bring these forms to the appointment.

If you have scheduled a virtual visit, please email the completed forms to your provider's office. Provider emails are available at [middlesexhealth.org/wellchild](https://middlesexhealth.org/wellchild).

**We look forward to seeing you soon!**



# SWYC:<sup>TM</sup> 6 months

6 months, 0 days to 8 months, 31 days  
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

## DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Makes sounds like "ga," "ma," or "ba" . . . . .	0	1	2
Looks when you call his or her name . . . . .	0	1	2
Rolls over . . . . .	0	1	2
Passes a toy from one hand to the other . . . . .	0	1	2
Looks for you or another caregiver when upset . . . . .	0	1	2
Holds two objects and bangs them together . . . . .	0	1	2
Holds up arms to be picked up . . . . .	0	1	2
Gets into a sitting position by him or herself . . . . .	0	1	2
Picks up food and eats it . . . . .	0	1	2
Pulls up to standing . . . . .	0	1	2

## 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? . . . . .	0	1	2
Does your child have a hard time in new places? . . . . .	0	1	2
Does your child have a hard time with change? . . . . .	0	1	2
Does your child mind being held by other people? . . . . .	0	1	2
Does your child cry a lot? . . . . .	0	1	2
Does your child have a hard time calming down? . . . . .	0	1	2
Is your child fussy or irritable? . . . . .	0	1	2
Is it hard to comfort your child? . . . . .	0	1	2
Is it hard to keep your child on a schedule or routine? . . . . .	0	1	2
Is it hard to put your child to sleep? . . . . .	0	1	2
Is it hard to get enough sleep because of your child? . . . . .	0	1	2
Does your child have trouble staying asleep? . . . . .	0	1	2

## PARENT'S CONCERNS

	Not at all	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have any concerns about your child's behavior?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
6 In general, how would you describe your relationship with your spouse/partner?	No tension <input type="radio"/>	Some tension <input type="radio"/>	A lot of tension <input type="radio"/>	Not applicable <input type="radio"/>				
7 Do you and your partner work out arguments with:	No difficulty <input type="radio"/>	Some difficulty <input type="radio"/>	Great difficulty <input type="radio"/>	Not applicable <input type="radio"/>				
8 During the past week, how many days did you or other family members read to your child?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

## 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...			
<b>1 I have been able to laugh and see the funny side of things</b>			
<input type="radio"/> 0 As much as I always could	<input type="radio"/> 1 Not quite so much now	<input type="radio"/> 2 Definitely not so much now	<input type="radio"/> 3 Not at all
<b>2 I have looked forward with enjoyment to things</b>			
<input type="radio"/> 0 As much as I ever did	<input type="radio"/> 1 Rather less than I used to	<input type="radio"/> 2 Definitely less than I used to	<input type="radio"/> 3 Hardly at all
<b>3* I have blamed myself unnecessarily when things went wrong</b>			
<input type="radio"/> 3 Yes, most of the time	<input type="radio"/> 2 Yes, some of the time	<input type="radio"/> 1 Not very often	<input type="radio"/> 0 No, never
<b>4 I have been anxious or worried for no good reason</b>			
<input type="radio"/> 0 No, not at all	<input type="radio"/> 1 Hardly ever	<input type="radio"/> 2 Yes, sometimes	<input type="radio"/> 3 Yes, very often
<b>5* I have felt scared or panicky for no good reason</b>			
<input type="radio"/> 3 Yes, quite a lot	<input type="radio"/> 2 Yes, sometimes	<input type="radio"/> 1 No, not much	<input type="radio"/> 0 No, not at all
<b>6* Things have been getting on top of me</b>			
<input type="radio"/> 3 Yes, most of the time I haven't been able to cope at all	<input type="radio"/> 2 Yes, sometimes I haven't been coping as well as usual	<input type="radio"/> 1 No, most of the time I have coped quite well	<input type="radio"/> 0 No, I have been coping as well as ever
<b>7* I have been so unhappy that I have had difficulty sleeping</b>			
<input type="radio"/> 3 Yes, most of the time	<input type="radio"/> 2 Yes, sometimes	<input type="radio"/> 1 Not very often	<input type="radio"/> 0 No, not at all
<b>8* I have felt sad or miserable</b>			
<input type="radio"/> 3 Yes, most of the time	<input type="radio"/> 2 Yes, quite often	<input type="radio"/> 1 Not very often	<input type="radio"/> 0 No, not at all
<b>9* I have been so unhappy that I have been crying</b>			
<input type="radio"/> 3 Yes, most of the time	<input type="radio"/> 2 Yes, quite often	<input type="radio"/> 1 Only occasionally	<input type="radio"/> 0 No, never
<b>10* The thought of harming myself has occurred to me</b>			
<input type="radio"/> 3 Yes, quite often	<input type="radio"/> 2 Sometimes	<input type="radio"/> 1 Hardly ever	<input type="radio"/> 0 Never

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