The following Infant Health Screening Tool was created in partnership with the Helen DeVos Children's Hospital Pediatric Clinic staff to be used for a clinic research project. The questions have been altered from the original Infant Screening Tool to accommodate the needs of a high-volume medical practice. Because of this alteration of the questions, some of them cannot be considered research-based.

All "Yes" answers on the screening tool indicate that follow-up is needed.

We have also created a Decision Tree Referral Guide to be used with the Infant Health Screening Tool. It will give you guidance on which Decision Tree to use with positive screens. For questions without a specific Decision Tree we have included community resources that may be helpful. We have also listed screening tools - the Perceived Stress Scale (PSS4) and the Edinburgh Postnatal Depression Scale (EPDS) - that can be used for additional follow-up if desired. The Decision Tree Referral Guide may be found under **Infant Screeners**. The Decision Trees and other resources are available in the **Resources.**

THE HEALTH OF YOU AND YOUR BABY IS IMPORTANT TO US…

INFANT (0 TO 1 YEAR)

Taking a few minutes now to answer these questions will help us provide you with the care and services you and your baby need. Please remember, everything that affects you affects your baby. All information on this form will be kept confidential.

Date_____
Infant's Name_____ Birth Date_____
Your Name_____ Relationship to Infant_____

1.	Do you or your partner have any problems/concerns with breast feeding?	□ Yes □ No □ Not Breastfdg
2.	Are you having sex without using birth control?	□ Yes □ No
3.	Do you or your partner have any questions/concerns about your options for birth control?	□ Yes □ No
4.	Is it difficult to find someone you can count on when you need help or need a break?	□ Yes □ No
5.	Is it difficult to take time to read, talk, or play with your baby daily?	□ Yes □ No
6.	Do you have any concerns about you and your baby bonding?	□ Yes □ No
7.	When feeding your baby do you prop the bottle?	□ Yes □ No □ Not Bottlefdg
8.	Do you have any concerns about your baby's development or behavior?	□ Yes □ No
9.	Have you ever thought of spanking your baby?	□ Yes □ No
10.	Have you ever been afraid you or your partner might lose control and hurt your baby or children?	□ Yes □ No
11.	Are there areas in your home that could be dangerous for your baby/children, such as stairways, water (temperature or drowning), electrical, lead, poisons, fire, or pets?	□ Yes □ No
12.	Does your baby ever ride in a car without being in a rear facing car seat?	□ Yes □ No
13.	Does your baby sleep anywhere besides alone, in a crib, on his back?	□ Yes □ No
14.	Have you moved more than once in the last year?	□ Yes □ No
15.	Do you ever feel that you do not live in a safe place?	□ Yes □ No
16.	Do you feel as though you are currently under a lot of stress?	□ Yes □ No
17.	During the last two weeks have you felt unhappy, sad, or hopeless?	□ Yes □ No
18.	During the last two weeks, have you had little interest or pleasure in doing things you used to enjoy?	□ Yes □ No

OVER

19.	Do you or your partner have a history of nerves, depression, or other mental health issues?	☐ Yes ☐ No
20.	In the past year, has anyone pushed, punched, kicked, hit, or threatened to hurt you?	☐ Yes ☐ No
21.	While you were pregnant did you use any tobacco, alcohol, or street drugs including marijuana?	☐ Yes ☐ No
22.	Does anyone in your household currently smoke?	☐ Yes ☐ No
23.	Do you or your partner drink more than 7 drinks (beer/liquor/wine/wine coolers) per week?	☐ Yes ☐ No
24.	Do you or anyone in your household use any street drugs, including marijuana?	☐ Yes ☐ No
25.	Do you have any trouble meeting your basic needs such as transportation, food, clothing, housing, child care?	☐ Yes ☐ No
26.	Do you have any difficulties reading or understanding materials given to you by your medical provider?	☐ Yes ☐ No
27.	Are there any faith, spiritual, or cultural practices that may affect the medical care of your baby?	☐ Yes ☐ No
28.	Have you previously been screened and referred for any of the concerns above?	☐ Yes ☐ No

29. I would like more information about_____

_____

Thank you!

HEALTHY KENT 2010

Healthy Kent 2010
Infant Health Team

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