

The following Infant Screening Tool was created to be used at well child exams of infants from birth to their first birthday. The questions are research based. The screener can be self-administered or completed by office/clinic staff.

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. Are you currently using birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have someone who could take care of your baby if you need a break?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Who can you count on when you need help?	<input type="checkbox"/> No one <input type="checkbox"/> Family members <input type="checkbox"/> Father of baby <input type="checkbox"/> Partner <input type="checkbox"/> Friends <input type="checkbox"/> Faith community <input type="checkbox"/> Community agencies <input type="checkbox"/> Other
5. How often do you read, talk, or play with your baby?	<input type="checkbox"/> Throughout the day <input type="checkbox"/> Daily <input type="checkbox"/> Once in awhile <input type="checkbox"/> Seldom
6. Do you have any concerns about you and your baby bonding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. How often is your baby held during bottle feeding?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Not bottle feeding
8. Do you have any concerns about your baby's development or behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. How would you discipline your child? (Mark all that apply)	<input type="checkbox"/> Time out <input type="checkbox"/> Spanking <input type="checkbox"/> Redirection/Distraction <input type="checkbox"/> Other <input type="checkbox"/> I don't know
10. Have you ever been afraid you or your partner might lose control and hurt your baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are there areas in your home that could be dangerous for your baby, such as stairways, water (temperature or drowning), electrical, lead, poisons, fire, pets?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you always put your baby in a rear facing car seat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Does your baby always sleep alone, on his/her back, in a crib or bassinette?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. How many times have you moved in the last year?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3 or more
15. Do you feel that you live in a safe place?	<input type="checkbox"/> Yes <input type="checkbox"/> No

16. How do you rate your current stress level?	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
17. During the last two weeks have you felt unhappy, sad, or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. During the last two weeks, have you had little interest or pleasure in doing things you used to enjoy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Do you or anyone in your family have a history of nerves, depression, or other mental health issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. In the past year, has anyone pushed, punched, kicked, hit, or threatened to hurt you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. While you were pregnant, did you use any tobacco, alcohol, or street drugs, including marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Do you or anyone in your household currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Does anyone in your household use alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. How much beer/liquor/wine/wine coolers do you drink?	<input type="checkbox"/> Do not drink <input type="checkbox"/> Less than 7 drinks per week <input type="checkbox"/> More than 7 drinks per week
25. Do you or anyone in your household use any street drugs, including marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Do you have any difficulties reading or understanding materials given to you by your medical provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Do you have any trouble meeting your basic needs such as transportation, food, clothing, housing, child care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Are there any faith, spiritual, or cultural practices that may affect the medical care of your infant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

29. I would like more information about _____

Thank you!



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