2 months

Please complete these forms before your visit today.

Thank you!

PLACE PATIENT LABEL HERE

Mother's OB or Doctor's Name _____

Phone: _____

As you have recently had a baby, we would like to know how you are feeling.

Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 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 very 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

Score: _____

Office use only ☐ Declined ☐ Home Visiting ☐ Counseling

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199.

Staying Healthy Assessment

0-6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (specify)			Need Help with Form ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you breastfeed your baby?	Yes	No	Skip	*Nutrition*
2	Are you concerned about your baby's weight?	No	Yes	Skip	*Physical Activity*
3	Does your baby watch any TV?	No	Yes	Skip	
4	Does your home have a working smoke detector?	Yes	No	Skip	*Safety*
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on his/her back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
11	Do you always place your baby in a rear-facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the correct one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	*Dental Health*
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*

16	Does your child have any family members who have or have had a problem with alcohol or other drugs?	No	Yes	Skip	
17	Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health conditions?	No	Yes	Skip	*Home Environment*
18	(For parents) Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes	Skip	
19	Has your child ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons?	No	Yes	Skip	
20	Has anything really scary or upsetting happened to your child or anyone in your family?	No	Yes	Skip	
21	In the last year, have you been worried that your food would run out before you were able to get more?	No	Yes	Skip	*Other Questions*
22	In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons?	No	Yes	Skip	
23	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Drug, Alcohol & Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Home Environment	☐	☐	☐	☐	

PCP's Signature:	Print Name:	Date:

GARDNER
Packard Children's Health Center

Family Needs Screening[1,2]

Our goal at Gardner Packard Children's Health Center is to provide the best possible care for your child and family. We would like to make sure you know resources available to you for your family's needs. Please answer both questions and give to your child's doctor at the beginning of the visit. Thank You!

1. Which of these would you like help with today? (Check all that apply)

   - ❑ Food
   - ❑ Housing
   - ❑ Living conditions (like mold in your home)
   - ❑ Utilities
   - ❑ Transportation
   - ❑ Tutoring or Homework Help
   - ❑ Childcare or preschool

   - ❑ None of these

2. Which of the concerns above is most important to talk about today?

Adapted from: [1] Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health Related Social Needs Screening Tool and [2] WE-CARE: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education. Modified on 6/12/2018.

GARDNER
Packard Children's Health Center

Medical Record Number

Patient Name

Addressograph or Label

TUBERCULOSIS RISK FACTOR ASSESSMENT

Exposure Risk

1. Has a family member or someone your child has been in contact with had tuberculosis disease? ❑ Yes ❑ No
2. Has your child, a family member, or someone your child has been in contact with had a positive TB test or received medications for TB? ❑ Yes ❑ No
3. Was your child born in another country*? ❑ Yes ❑ No
4. Has your child traveled outside of the United States for more than a month? ❑ Yes ❑ No

*Excluding Canada, Australia, New Zealand, or Western and Northern European countries

I attest that the above information is true to the best of my knowledge.

Parent/Guardian Signature: _____Date: _____