FAMILY HEALTH
ASSOCIATES

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PEDIATRIC HEALTH MAINTENANCE – 2 MONTHS
PATIENT QUESTIONNAIRE

General

Do you have any concerns about your baby? Yes___ No___

If "yes," please specify:

_____

Will you be returning to work and/or will your child attend daycare? Yes___ No___

Feeding and Sleeping

What do you feed your baby? ☐ Breastmilk ☐ Formula (brand/type: _____)

Ounces per feeding (if bottle fed): _____ oz.

My baby feeds every ___ hours during the day and wakes up ___ times during the night to feed.

Where does your baby sleep? ☐ Crib/bassinet ☐ Parent's Bed ☐ Other

Does your baby sleep on their back? Yes___ No___

Do you think your baby's bowel movements are normal? Yes___ No___

Environment

What type of housing do you have? ☐ House ☐ Apartment ☐ Manufactured Home

What year was your home built? _____

Who lives with you in your home? _____

What do you do to calm your baby? _____

Do you have pets? Yes___ No___

Does anyone smoke in your house? Yes___ No___

Safety

Does your home have functioning smoke detectors? Yes___ No___

Is your water heater turned down below 120 degrees? Yes___ No___

Does your baby ride in a rear-facing car seat? Yes___ No___

Does your child ever ride in the front seat of a vehicle? Yes___ No___

Do you leave your baby alone on the changing table, sofa, or bed? Yes___ No___

Are you afraid of your partner or anyone close to you? Yes___ No___

Do you feel overly stressed or unsupported? Yes___ No___

Patient Name: _____

Completed by (name and relationship to patient: _____ Date: _____

ASQ-3 Ages & Stages Questionnaires®

1 month 0 days through 2 months 30 days

2 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender:
◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

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2 Month Questionnaire

1 month 0 days through 2 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	◯	◯	◯	____
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	◯	◯	◯	____
3. When you speak to your baby, does she make sounds back to you?	◯	◯	◯	____
4. Does your baby smile when you talk to him?	◯	◯	◯	____
5. Does your baby chuckle softly?	◯	◯	◯	____
6. After you have been out of sight, does your baby smile or get excited when she sees you?	◯	◯	◯	____

COMMUNICATION TOTAL ____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	◯	◯	◯	____
2. When your baby is on her tummy, does she turn her head to the side?	◯	◯	◯	____
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	◯	◯	◯	____
4. When your baby is on her back, does she kick her legs?	◯	◯	◯	____
5. While your baby is on his back, does he move his head from side to side?	◯	◯	◯	____
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	◯	◯	◯	____

GROSS MOTOR TOTAL ____

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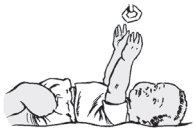
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Is your baby's hand usually tightly closed when he is awake? (*If your baby used to do this but no longer does, mark "yes."*)	◯	◯	◯	____
2. Does your baby grasp your finger if you touch the palm of her hand? 	◯	◯	◯	____
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	◯	◯	◯	____
4. Does your baby touch her face with her hands?	◯	◯	◯	____
5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? 	◯	◯	◯	____ *
6. Does your baby grab or scratch at her clothes?	◯	◯	◯	____

FINE MOTOR TOTAL ____

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby look at objects that are 8–10 inches away?	◯	◯	◯	____
2. When you move around, does your baby follow you with his eyes?	◯	◯	◯	____
3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?	◯	◯	◯	____
4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?	◯	◯	◯	____
5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?	◯	◯	◯	____
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	◯	◯	◯	____

PROBLEM SOLVING TOTAL ____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	◯	◯	◯	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	◯	◯	◯	___
3. Does your baby smile at you?	◯	◯	◯	___
4. When you smile at your baby, does she smile back?	◯	◯	◯	___
5. Does your baby watch his hands? 	◯	◯	◯	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	◯	◯	◯	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain: ◯ YES ◯ NO

2. Does your baby move both hands and both legs equally well? If no, explain: ◯ YES ◯ NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: ◯ YES ◯ NO

OVERALL *(continued)*

4. Has your baby had any medical problems? If yes, explain: ◯ YES ◯ NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain: ◯ YES ◯ NO

6. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

2 Month ASQ-3 Information Summary

1 months 0 days through 2 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	22.77		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	30.16		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	24.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	33.71		●	●	●	●	●	●	●	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Passed newborn hearing screening test? Yes **NO**
   Comments:

2. Moves both hands and both legs equally well? Yes **NO**
   Comments:

3. Family history of hearing impairment? **YES** No
   Comments:

4. Any medical problems? **YES** No
   Comments:

5. Concerns about behavior? **YES** No
   Comments:

6. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the ▭ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

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Well Child: 2 Months

Name: _____ Date: _____ Length: _____ in. (_____ %)

Weight: _____ lbs. _____ oz. (_____ %) Head Circumference: _____ cm. (_____ %)

IMMUNIZATIONS: Dtap, Hib, Polio, Pneumococcal conjugate, Rotavirus, and Hepatitis B.
Your baby may develop a fever, fussiness, sleeplessness, and/or tenderness at the injection site(s) for 24-48 hours after receiving immunizations. You may give them acetaminophen for these symptoms. DO NOT give them ibuprofen (Advil/Motrin) until 6 months of age.

ACETAMINOPHEN (Tylenol) DOSAGE

Child's Weight	Infant Dose (160 mg/5mL)
6-12lbs	1.25mL
12-18lbs	2.5mL
18-24lbs	3.75mL (3/4 tsp)
over 24lbs	5mL (1 tsp)

Acetaminophen may be given every 4 hours, but not more than four times in 24 hours. Please call the office if fever persists for more than 2 days or if you have any questions.
NEXT VISIT: 4 months

How Your Family is Doing:	**Your Growing Baby**
▪ If you are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and SNAP can also provide information and assistance. ▪ Find ways to spend time with your partner. Keep in touch with family and friends. ▪ Find safe, loving child care for your baby. You can ask us for help. ▪ Know that it is normal to feel sad about leaving your baby with a caregiver or putting them into child care.	▪ Have simple routines each day for bathing, feeding, sleeping, and playing. ▪ Hold, talk to, cuddle, read to, sing to, and play often with your baby. This helps you connect with and relate to them. ▪ Learn what your baby does and does not like. ▪ Develop a schedule for naps and bedtime. Put them to bed awake but drowsy so they learn to fall asleep on their own. ▪ Don't have a TV on in the background or use a TV or other digital media to calm your baby. ▪ Put your baby on their tummy for short periods of playtime. Don't leave them alone during tummy time or allow them to sleep on their tummy. ▪ Notice what helps calm your baby, such as a pacifier, their fingers, or their thumb. Stroking, talking, rocking, or going for walks may also work. ▪ Never hit or shake your baby

American Academy of Pediatrics, "Bright Futures Parent Handout 2 Month – English," https://pediatrics.christieclinic.com/wp-content/uploads/2019/11/parent-handouts-2-month-english.pdf

Feeding Your Baby

- Feed your baby only breast milk or iron-fortified formula until they are about 6 months old.
- Avoid feeding your baby solid foods, juice, and water until they are about 6 months old.
- Feed your baby when you see signs of hunger. Look for them to put their hand to their mouth, suck, root, and fuss.
- Stop feeding when you see signs your baby is full. You can tell when they turn away, close their mouth, and relax their arms and hands.
- Burp your baby during natural feeding breaks.

If Breastfeeding

- Feed your baby on demand. Expect to breastfeed 8 to 12 times in 24 hours.
- Give your baby vitamin D drops (400 IU a day).
- Continue to take your prenatal vitamin with iron.
- Eat a healthy diet.
- Plan for pumping and storing breast milk. Let us know if you need help. If you pump, be sure to store your milk properly so it stays safe for your baby.

If Formula Feeding

- Feed your baby on demand. Expect them to eat about 6 to 8 times each day, or 26 to 28 oz of formula per day.
- Make sure to prepare, heat, and store the formula safely. If you need help, ask us.
- Hold your baby so you can look at each other when you feed them.
- Always hold the bottle. Never prop it.

Safety

- Use a rear-facing–only car safety seat in the back seat of all vehicles.
- Never put your baby in the front seat of a vehicle that has a passenger airbag.
- Your baby's safety depends on you. Always wear your lap and shoulder seat belt. Never drive after drinking alcohol or using drugs. Never text or use a cell phone while driving.
- Always put your baby to sleep on their back in their own crib, not your bed.
    - Your baby should sleep in your room until they are at least 6 months old.
    - Make sure your baby's crib or sleep surface meets the most recent safety guidelines.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Swaddling should not be used after 2 months.
- Prevent scalds or burns. Don't drink hot liquids while holding your baby.
- Prevent tap water burns. Set the water heater so the temperature at the faucet is at or below 120°F /49°C.
- Keep a hand on them when dressing or changing them on a changing table, couch, or bed.
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- **IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222**

How You Are Feeling

- Take care of yourself so you have the energy to care for your baby.
- Talk with me or call for help if you feel sad or very tired for more than a few days.
- Find small but safe ways for your other children to help with the baby, such as bringing you things you need or holding the baby's hand.
- Spend special time with each child reading, talking, and doing things together.

WHAT TO EXPECT AT YOUR CHILD'S 4 MONTH VISIT

We will talk about:

- Caring for your baby, your family, and yourself
- Creating routines and spending time with your baby
- Keeping teeth healthy
- Feeding your baby
- Keeping your baby safe at home and in the car