



Baby's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

## Bright Futures Parent Supplemental Questionnaire 2 to 5 Day (First Week) Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going.  
Please circle Yes or No for each question. Thank you.

### How You Are Feeling: Parental Well-being

Are you happy with your relationships with your partner, family, and friends?	Yes	No
Are you able to pay for housing?	Yes	No
Do you have enough to eat?	Yes	No
Do you sleep when your baby sleeps?	Yes	No
Does your partner help take care of your baby?	Yes	No
Do other family members and friends help you take care of your baby?	Yes	No
Do you feel that you are getting used to your new baby?	Yes	No
Are you happy with your baby?	Yes	No

### Getting Used to Your Baby: Newborn Transition

Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib?	Yes	No
Does your baby sleep in your room?	Yes	No

### Feeding Your Baby: Nutritional Adequacy

Does your baby eat well?	Yes	No
Are you worried about your child's weight?	No	Yes
Do you have pain from breastfeeding?	No	Yes
Are you able to burp your baby?	Yes	No
Can you tell when your baby is hungry?	Yes	No
Can you tell when your baby is full?	Yes	No
Is your baby having at least 6–8 wet diapers each day?	Yes	No



### Safety

Is your baby's car safety seat rear-facing in the back seat of the car?	Yes	No
Are your home and car smoke free?	Yes	No
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No
Is your hot water temperature at or below 120°F at the faucet?	Yes	No

### Baby Care: Newborn Care

Do you know how to take your baby's temperature rectally?	Yes	No
Do you have a list of emergency numbers?	Yes	No



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# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Name: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_

Baby's Date of Birth: \_\_\_\_\_

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As you are pregnant or 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      This would mean: "I have felt happy most of the time" during the past week.
- No, not very often      Please complete the other questions in the same way.
- No, not at all

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

Administered/Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>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.

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# Bright Futures Parent Handout 2 to 5 Day (First Week) Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

## How You Are Feeling

- Call us for help if you feel sad, blue, or overwhelmed for more than a few days.
- Try to sleep or rest when your baby sleeps.
- Take help from family and friends.
- Give your other children small, safe ways to help you with the baby.
- Spend special time alone with each child.
- Keep up family routines.
- If you are offered advice that you do not want or do not agree with, smile, say thanks, and change the subject.

PARENTAL WELL-BEING

## Feeding Your Baby

- Feed only breast milk or iron-fortified formula, no water, in the first 6 months.
- Feed when your baby is hungry.
  - Puts hand to mouth
  - Sucks or roots
  - Fussing
- End feeding when you see your baby is full.
  - Turns away
  - Closes mouth
  - Relaxes hands

NUTRITIONAL ADEQUACY

## If Breastfeeding

- Breastfeed 8–12 times per day.
- Make sure your baby has 6–8 wet diapers a day.
- Avoid foods you are allergic to.
- Wait until your baby is 4–6 weeks old before using a pacifier.
- A breastfeeding specialist can give you information and support on how to position your baby to make you more comfortable.
- WIC has nursing supplies for mothers who breastfeed.

NUTRITIONAL ADEQUACY

## If Formula Feeding

- Offer your baby 2 oz every 2–3 hours, more if still hungry.
- Hold your baby so you can look at each other while feeding
- Do not prop the bottle.
- Give your baby a pacifier when sleeping.

NUTRITIONAL ADEQUACY

## Baby Care

- Use a rectal thermometer, not an ear thermometer.
- Check for fever, which is a rectal temperature of 100.4°F/38.0°C or higher.
- In babies 3 months and younger, fevers are serious. Call us if your baby has a temperature of 100.4°F/38.0°C or higher.
- Take a first aid and infant CPR class.
- Have a list of phone numbers for emergencies.
- Have everyone who touches the baby wash their hands first.
- Wash your hands often.
- Avoid crowds.
- Keep your baby out of the sun; use sunscreen only if there is no shade.
- Know that babies get many rashes from 4–8 weeks of age. Call us if you are worried.

NEWBORN CARE

## Getting Used to Your Baby

- Comfort your baby.
  - Gently touch baby's head.
  - Rocking baby.
- Start routines for bathing, feeding, sleeping, and playing daily.
- Help wake your baby for feedings by
  - Patting
  - Changing diaper
  - Undressing

NEWBORN TRANSITION

- Put your baby to sleep on his or her back.
  - In a safe crib, in your room, not in your bed.
  - Swaddled or with tucked blankets.
  - Do not use loose, soft bedding or toys in the crib such as comforters, pillows, or pillow-like bumper pads.
- Use a crib with slats close together.
  - 2<sup>3</sup>/<sub>8</sub> inches apart or less
- Keep the baby from getting too warm or cold.

NEWBORN TRANSITION

## Safety

- The car safety seat should be rear-facing in the middle of the back seat in all vehicles.
- Your baby should never be in a seat with a passenger air bag.
- Keep your car and home smoke free.
- Keep your baby safe from hot water and hot drinks.
- Do not drink hot liquids while holding your baby.
- Make sure your water heater is set at lower than 120°F.
- Test your baby's bathwater with your wrist.
- Always wear a seat belt and never drink and drive.

SAFETY

## What to Expect at Your Baby's 1 Month Visit

### We will talk about

- Any concerns you have about your baby
- Feeding your baby and watching him or her grow
- How your baby is doing with your whole family
- Your health and recovery
- Your plans to go back to school or work
- Caring for and protecting your baby
- Safety at home and in the car



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