

# 2 Month

## Well Check Questionnaire

Please answer these questions about your child.

Skip any questions that you cannot answer or that do not apply.

Your answers will help us provide you and your child with the best possible care.

Do you have any questions or concerns that you would like to discuss with your doctor? .....

☐ Yes ☐ No

If yes, please describe: .....

### NUTRITION

1. What does your child eat? ☐ Only breast milk ☐ Some breast milk, some formula ☐ Only formula

If your child is breastfeeding: [If your child is not breastfeeding, please skip to SAFETY.]

2. Do you give your child vitamin D drops? .....

☐ No ☐ Yes

### SAFETY

3. Do you always put your child to sleep on his or her back? .....

☐ No ☐ Yes

4. Do you place your child in a rear-facing car seat in the backseat for every car ride? .....

☐ No ☐ Yes

5. Does your home have working smoke detectors? .....

☐ No ☐ Yes

6. Is your child ever left unattended (such as on a changing table or bed, or in a bath)? .....

☐ Yes ☐ No

### YOUR GROWING CHILD

7. Does your child make sounds that let you know he or she is happy or upset? .....

☐ Not yet ☐ Somewhat ☐ Yes, often

8. Does your child follow a moving toy with his or her eyes? .....

☐ Not yet ☐ Somewhat ☐ Yes, often

9. Does your child turn his or her head to find the person who is talking? .....

☐ Not yet ☐ Somewhat ☐ Yes, often

10. Does your child hold his or her head steady when being pulled up to a sitting position? .....

☐ Not yet ☐ Somewhat ☐ Yes, often

11. Does your child keep his or her head steady when held in a sitting position? .....

☐ Not yet ☐ Somewhat ☐ Yes, often

### FAMILY LIFE

12. Do you put your child down to sleep when he or she is drowsy but still awake? .....

☐ No ☐ Yes

13. Do you hold, talk, and/or sing to your child every day? .....

☐ No ☐ Yes

14. Since your child's last checkup, has your family or child experienced any major issues (such as illness, move, job change or loss, separation or divorce, death in the family)? .....

☐ Yes ☐ No

If yes, please list: .....

15. Who takes care of your child (other than you)? Check all that apply:

☐ Child's parent(s)/other family ☐ Day care ☐ Other ☐ No one else

16. Do you ever hit or shake your child when feeling angry or frustrated? .....

☐ Yes ☐ No

### For mother of child:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

17. Little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

18. Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

# 2個月

## 健康核查問卷

請回答以下有關您孩子的問題。  
請跳過任何您無法回答或不適用的問題。  
您的回答將幫助我們為您和孩子提供最佳護理。

您有任何疑問或顧慮想要諮詢醫生嗎？.....  
如果回答「是」，請說明：\_\_\_\_\_

☐ 是 ☐ 否

### 營養

1. 您給孩子吃什麼？

☐ 僅母乳 ☐ 部分母乳，部分奶粉 ☐ 僅奶粉

如果您的孩子喝母乳：[如果您的孩子現在不喝母乳，請直接跳至「安全」。]

2. 您給孩子服用維生素D滴劑嗎？.....

☐ 否 ☐ 是

### 安全

3. 您總是讓孩子仰睡嗎？.....

☐ 否 ☐ 是

4. 您每次開車帶孩子出門時，是否讓孩子坐在後座的兒童安全座椅上，面朝後方？.....

☐ 否 ☐ 是

5. 您家裡裝有正常運作的煙霧探測器嗎？.....

☐ 否 ☐ 是

6. 您的孩子是否曾被獨自拋下，無人看顧（例如在尿布台或床上，或在浴缸裡？）.....

☐ 是 ☐ 否

### 成長中的孩子

7. 您的孩子是否會發出聲音，讓您知道他/她高興或沮喪？.....

☐ 還不會 ☐ 稍微 ☐ 是，經常

8. 孩子的眼睛是否會追蹤移動的玩具？.....

☐ 還不會 ☐ 稍微 ☐ 是，經常

9. 您的孩子是否會轉頭尋找正在說話的人？.....

☐ 還不會 ☐ 稍微 ☐ 是，經常

10. 當您的孩子被拉著坐起時，他/她的頭是否能保持穩定？.....

☐ 還不會 ☐ 稍微 ☐ 是，經常

11. 當您讓孩子維持坐姿時，他/她的頭是否能保持穩定？.....

☐ 還不會 ☐ 稍微 ☐ 是，經常

### 家庭生活

12. 當孩子睏倦但仍醒著時，您是否會將孩子放下，讓他/她睡覺？.....

☐ 否 ☐ 是

13. 您是否每天都會抱孩子，跟孩子說話，和/或對孩子唱歌？.....

☐ 否 ☐ 是

14. 從孩子上一次檢查至今，您的家人或孩子是否經歷任何重大變故（例如生病、搬家、換工作或失業、分居或離婚、家人去世）？.....  
如回答「是」，請列示：\_\_\_\_\_

☐ 是 ☐ 否

15. （除您之外）誰在照顧您的孩子？勾選所有適用選項：

☐ 孩子的父母/其他家人 ☐ 日間托兒 ☐ 其他 ☐ 無其他人

16. 您生氣或感覺受挫時責打或搖晃過孩子嗎？.....

☐ 是 ☐ 否

### 由孩子的母親回答：

過去2週以來，您受以下任何問題困擾的頻率是？

17. 做事失去興致或樂趣？

☐ 完全不會 ☐ 有幾天 ☐ 一半時間以上 ☐ 幾乎每天

18. 感覺心情低落、抑鬱或無望？

☐ 完全不會 ☐ 有幾天 ☐ 一半時間以上 ☐ 幾乎每天