START # 167 Plate #076 Visit #015

Participant ID ☐☐ ☐☐☐☐ **Initials** ☐☐☐

Centre # *Participant #* *For Office Use Only* *F M L*

A. BABY'S INFORMATION

Date when information was collected: **20** ☐☐ ☐☐ ☐☐
year month day

Date of your baby's last doctor's visit: **20** ☐☐ ☐☐ ☐☐
year month day

1. At this visit what was your baby's:

a. Length ☐☐.☐ cm

b. Weight: ☐☐☐☐.☐ gm

c. Head Circumference ☐☐.☐ cm

2. Is your baby's immunization up-to-date? ☐ Yes ☐ No ☐ DK

B. FEEDING

3. Please complete this chart.

Type of feeding	Currently used method *(Check all that apply)*	Number of Feeds per day	Average amount of each feed *(Time/oz/mL)*
Breast milk	☐	☐☐	______
Formula	☐	☐☐	______
Pablum/baby cereals	☐	☐☐	______
Other solids	☐	☐☐	______

4. If you chose other solids in the previous question- what type:

☐ **Fruit/Vegetable Puree**

☐ **Pre-lacteals** *(eg. ghee, honey, gripe water, other traditional foods)*

☐ **Other, specify:** ______________________

5. a) Does your physician have any concerns about your baby's weight since birth?

☐ No

☐ Yes → ☐ **a) not gaining enough weight**
☐ **b) gaining too much weight**

b) Do YOU have any concerns about your baby's weight since birth?

☐ No

☐ Yes → ☐ **a) not gaining enough weight**
☐ **b) gaining too much weight**

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C. INFANT SLEEP QUESTIONNAIRE (BISQ):

(The following questions pertain to your baby's sleeping arrangement and habits:)

6. What is your baby's current sleep arrangement:

- ☐ Infant crib in separate room
- ☐ Infant crib in parents' room
- ☐ Infant crib in room with sibling
- ☐ In parents' bed
- ☐ Other, specify: ____________________________________

7. In what position does your child spend sleeping most of the time?

- ☐ On his/her belly
- ☐ On his/her side
- ☐ On his/her back

8. How much time does your child spend sleeping during the NIGHT (7PM - 7AM): ☐☐ Hours ☐☐ Mins

9. How much time does your child spend sleeping during the DAY (7AM - 7PM): ☐☐ Hours ☐☐ Mins

10. Average number of night wakings per night: ☐☐

11. How much time during the night does your child spend in wakefulness (from 10pm to 6am): ☐☐ Hours ☐☐ Mins

12. How long does it take to put your baby to sleep in the evening? ☐☐ Hours ☐☐ Mins

13. When does your baby usually fall asleep for the night: ☐☐ Hours ☐☐ Mins

14. How does your baby fall asleep?

- ☐ While feeding
- ☐ Being rocked
- ☐ Being held
- ☐ In bed alone
- ☐ In bed near parent

15. Do you or your physician consider your child's sleep as a problem?

- ☐ A very serious problem
- ☐ A small problem
- ☐ Not a problem at all

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D. MOTHER'S INFORMATION

16. a) Are you feeling sleep-deprived? ☐ No ☐ Yes

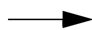
b) How many hours in a 24 hour period do you sleep? ☐☐ Hours ☐☐ Mins

17. a) Are you working outside of the home? ☐ No ☐ Yes

b) How many hours are you away from your baby per day? ☐☐ Hours ☐☐ Mins

18. Do you have help with the baby?

☐ No

☐ Yes  ☐ **From a family member:** ______________________

☐ **From outside the family:** ______________________

19. The next ten questions are about how you have been feeling in the past 4 weeks. *(Read out the scale for each option)***.**
(None of the time - 1; A little of the time - 2; Some of the time - 3; Most of the time - 4; All of the time - 5)

In the past 4 weeks, about how often did you feel:	**1**	**2**	**3**	**4**	**5**
a. worn out for no good reason?	☐	☐	☐	☐	☐
b. nervous?	☐	☐	☐	☐	☐
c. so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
d. hopeless?	☐	☐	☐	☐	☐
e. restless or fidgety?	☐	☐	☐	☐	☐
f. so restless you could not sit still?	☐	☐	☐	☐	☐
g. depressed?	☐	☐	☐	☐	☐
h. that everything was an effort?	☐	☐	☐	☐	☐
i. so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
J. worthless?	☐	☐	☐	☐	☐

20. Have you ever been diagnosed by a doctor as having depression, not during pregnancy?

No ☐ Yes ☐ → Age diagnosed ☐☐

21. Have you ever been diagnosed by a doctor as having depression, during or after a previous pregnancy?

No ☐ Yes ☐ → Age diagnosed ☐☐

Mother: 3 Month Post-Partum Form

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22. Were you diagnosed by a doctor as having depression during your most recent pregnancy?

No ☐ Yes ☐ → Gestational age at diagnosis ☐☐

23. Have you been diagnosed by a doctor as having depression since giving birth?

No ☐ Yes ☐ → Months postpartum at diagnosis ☐☐

24. During the 12 months prior to your pregnancy, during your pregnancy, or since giving birth, have you ever taken any of the following medications or had any of the following treatments? *(Check all that apply)*

	12 months prior		**During pregnancy**		**Postpartum**	
	No	Yes	No	Yes	No	Yes
a. Anti-depressant medication	☐	☐	☐	☐	☐	☐
b. Anti-anxiety medication	☐	☐	☐	☐	☐	☐
c. Talk therapy	☐	☐	☐	☐	☐	☐

Form completed by: ______________________ ________ **Date of completion:** 20 ☐☐ ☐☐ ☐☐
(please print) *Last Name* *First Initial* *year* *month* *day*