



START # 167

Plate #089

Visit #018

Participant ID
 Centre # Participant #

Initials
 F M L

For Office Use Only

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	<input type="checkbox"/>	<input type="text"/> <input type="text"/>	_____
Formula	<input type="checkbox"/>	<input type="text"/> <input type="text"/>	_____
Pablum/baby cereals	<input type="checkbox"/>	<input type="text"/> <input type="text"/>	_____
Other solids	<input type="checkbox"/>	<input type="text"/> <input type="text"/>	_____

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. so nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. so restless you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. so sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
 →



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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Anti-anxiety medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Talk therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____
 (please print) Last Name

 First Initial

Date of completion: 20
 year month day