SWYC™: 6 months

6 months, 0 days to 8 months, 31 days

V1.06, 9-1-16

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Makes sounds like "ga," "ma," or "ba"	0	1	2
Looks when you call his or her name	0	1	2
Rolls over	0	1	2
Passes a toy from one hand to the other	0	1	2
Looks for you or another caregiver when upset	0	1	2
Holds two objects and bangs them together	0	1	2
Holds up arms to be picked up	0	1	2
Gets into a sitting position by him or herself	0	1	2
Picks up food and eats it	0	1	2
Pulls up to standing	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

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********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

		Yes	No
1	Does anyone smoke tobacco at home?	(Y)	(N)
2	In the last year, have you ever drunk alcohol or used drugs more than you meant to?	(Y)	(N)
3	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	(Y)	(N)
4	Has a family member's drinking or drug use ever had a bad effect on your child?	(Y)	(N)
5	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food?	(Y)	(N)

Over the past two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
6	Having little interest or pleasure in doing things?	(0)	(1)	(2)	(3)
7	Feeling down, depressed, or hopeless?	(0)	(1)	(2)	(3)

		No tension	Some tension	A lot of tension	Not applicable
8	In general, how would you describe your relationship with your spouse/partner?	○	○	○	○
		No difficulty	**Some difficulty**	**Great difficulty**	**Not applicable**
9	Do you and your partner work out arguments with:	○	○	○	○