

One Year Visit Questionnaire: Twin Supplement

This questionnaire should be completed approx. one year after the birth of child.

Questions ask about mum and baby, their health and how they have been doing over the past few months.

(This page should be removed by the HV on return to the office and enter the family ID)

Mother's Name: _____

Child's Name: _____

Date Completed: _____

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Family ID Number:

Date:

Mentor Initials:

Section One: Ages and Stages

NB: This needs to be completed when the baby is between 11 and 13 months

Send a copy of the 12 month Ages and Stages in advance or bring a copy with you to interview.

Follow guidelines for providing information/activity sheets or onward referrals in collaboration with the family following completion.

Note: This may be all you complete of questionnaire on this visit

Section Two: Your child and their Health

Date:

Mentor Initials:

Q2. How old is your child now? _____

Q3a. How would you say your child's health has been over the last six months?

Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Comments: _____

Q3b. Has your child been taken to the GP, health centre, or to A&E for any health problems over the last six months?

Yes ☐ No ☐

Q3c. If yes, then how many times have you seen, or talked on the telephone with any of the following about the physical health of your child? If none then enter 0 - do not leave blank.

A General Practitioner (GP) or family physician _____

A paediatrician _____

A public health nurse or practice nurse _____

Another medical practitioner (such as a hearing specialist) _____

Accident and Emergency or Outpatient _____

Other _____

Q4a. During the last 6 months, has your child ever stayed in hospital for at least one night for any illness (not hospital outpatient or emergency department visits)?

Yes ☐ No ☐

Q4b. If yes, how many times? _____ And for what reason?

Q5. Many children have accidents at some time. Over the last six months, has your baby had an accident, injury, or swallowed something that required a visit to the doctor, health centre or hospital?

(SS13 Keeping baby safe; SS15 Basic First Aid)

Yes ☐ No ☐

Q6. Has your child received any of the following scheduled check-ups?

- 3 months check-up (usually Public health nurse) ☐
- 9-11 month check-up (usually Public Health Nurse) ☐
- None of the above ☐

Q7. Has child received any vaccinations yet?

(SS8 Immunisations)

Yes ☐ No ☐

Q7a. If yes, which vaccinations has baby received?

Childs Age	Vaccination Type	
2 months	6 in 1 Vaccine Diphtheria Tetanus Whooping Cough (Pertussis), Hib (Haemophilus influenzae type b), Polio (Inactivated poliomyelitis), Hepatitis B PCV (Pneumococcal Conjugate Vaccine) MenB Vaccine (Meningococcal B Vaccine) Rotavirus Oral Vaccine	☐
4 months	6 in 1 Vaccine Diphtheria Tetanus Whooping Cough (Pertussis), Hib (Haemophilus influenzae type b), Polio (Inactivated poliomyelitis), Hepatitis B MenB Vaccine (Meningococcal B Vaccine) Rotavirus Oral Vaccine	☐
6 months	6 in 1 Vaccine Diphtheria Tetanus Whooping Cough (Pertussis), Hib (Haemophilus influenzae type b), Polio (Inactivated poliomyelitis), Hepatitis B PCV (Pneumococcal Conjugate Vaccine) MenC Vaccine (Meningococcal C Vaccine)	☐
12 months	MMR (Measles, Mumps and Rubella) MenB Vaccine (Meningococcal B Vaccine)	☐
13 months	Hib/MenC Vaccine Hib (Haemophilus Influenzae type b) and meningitis C) PCV (Pneumococcal Conjugate Vaccine)	☐
Other	Please Specify	☐

Child's Sleep

RR4 Sleep; RR5 Safety & Sleep

Recommended sleep of between 12-16 hours per day for 4–12-month-olds including naps (American academy for paediatrics)

Q8. Approximately how many hours sleep does your child have during (GUI 9 Months D3):

(a) the day? _____

(a) the night? _____ hours

Q9. Does your baby sleep...

More than expected

☐

Less than expected

☐

As expected

☐

Section Three: Baby/Child's Diet/Dental Care/Screen Time

Baby's Nutrition

Q10. Does baby drink anything else apart from milk or formula? (tick all that apply)

SS14 Teething; N14 Weaning to Solids; N19 Smart Drinks

Breastmilk	☐	Fruit juices/cordial/squash	☐
Cow's milk or formula	☐	Fizzy or soft drinks (E.g., lemonade, coke)	☐
Other milk alternatives (soy milk, coconut, goat/sheep milk etc)	☐	Herbal drinks	☐
Water	☐	Tea	☐
Baby juice	☐	Coffee	☐
Other (Please specify) _____			

Q11. Have you tried to breastfeed this baby? (include Colustrum in first few days after birth)

Yes ☐ No ☐ (if no, go to Q14).

Q12. Are you currently breastfeeding? (include partial/complementary breastfeeding)

N10 Continuing to Breastfeed, N11 Weaning your baby from the breast

Yes ☐ (if yes, go to Q14). No ☐

Q13a. If no, how old was he/she when completely stopped being breastfed? (Accept answer in days or weeks or months)

_____ Days _____ Weeks _____ Months

Q13b. What were the main reason(s) you stopped breastfeeding? (tick all that apply)

Not enough milk/hungry baby	☐	Partner/father wanted me to stop	☐
Inconvenience/fatigue	☐	Formula feeding preferable	☐
Difficulty with breastfeeding techniques	☐	Wanted to drink alcohol	☐
Sore nipples/engorged breast	☐	Embarrassment/social stigma	☐
Mother's illness	☐	Baby was sick (1)	☐
Planned to stop at this time	☐	Not enough time (1)	☐
Baby weaned himself/herself	☐	Practicalities (1)	☐
Physician told me to stop	☐	Previous problems with breastfeeding (1)	☐
Returned to work	☐		
Other (Please specify) _____			

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Q14a. Can I check, has baby had any solid food on a regular basis? (Regularly = more than twice a day for several continuous weeks; Solid food = baby cereals, pureed fruits etc but not milks or drinks)

SS12 Safe Feeding; N14 Weaning to Solids; N15 Recipes for Weaning

Yes ☐ No ☐ (if no, go to Q15).

Q14b. If yes, what foods does your baby eat and how regularly do they eat them?

Food Type	Never	Less than once a month	At least once a month	At least once a week	Most days	Once a day	2-3 times a day	4-5 times a day	6 or more times a day
a. Grains (e.g. cereals, pasta, bread)									
b. Vegetables (including juices)									
c. Fruits (including juices)									
d. Protein (e.g., meats, fish, nuts, beans, eggs, lentils)									
e. Dairy including dairy alternatives (e.g., milk, cheese, yoghurt, ice cream) Excluding breastmilk or formula									
f. Other foods (e.g., sugars and fats, sweets, crisps, and chips)									
g. Formula									
h. Breastmilk									
i. Plant based alternative drinks (soy milk, coconut, goat/sheep milk etc)									

Q14c. Are there any foods your baby really likes?

Q14d. Are there any foods your baby really doesn't like?

Dental Care:

SS21 Caring for Teeth

Q15. How often do you use a toothbrush or brush to clean your child's teeth and/or gums?

- | | |
|----------------------------|--------------------------|
| More than twice a day | ☐ |
| Twice a day | ☐ |
| Once a day | ☐ |
| Less often than once a day | ☐ |
| Rarely | ☐ |
| Not at all | ☐ |

Screen Use:

SS17 Television and Screen Time

Q16. Which (if any) of the following screens does your child use?

- | | |
|---------------------|--------------------------|
| Television | ☐ |
| Laptop | ☐ |
| Mobile Phone/Tablet | ☐ |
| Game console | ☐ |
| None | ☐ |

Other, please specify: _____

Q17. On average, how much screen time does your child have in a normal day?

_____ Hours _____ Minutes

Q18. In what circumstances does your child have use of a screen (think about what, where, when and how)?

Questionnaire Feedback:

This questionnaire is new to the PFL Home Visiting Program and we would welcome your thoughts on it. This section is to capture any recommendations or suggested changes to the content or structure or otherwise of the questionnaire. Feedback should ideally be captured for the Parent and Home Visitor

Parent: _____

Home Visitor: _____

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To be completed by Home Visitor at end:

Ages and Stages

This is ideally completed by the parent(s) in advance of this meeting. However, clarification and support to complete may be required. Check if parent needs any support and complete scoring with parent.

Q1a. Number of missing items: _____

Q1b. Do any scores need to be adjusted? *(if 3 or more items are missing in an area then do not score as screening may not be accurate; If 1 or 2 items are missing then an adjusted score should be calculated)*

Yes ☐ No ☐

Comment: _____

Q1c. Scores for each category

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	15.64		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	21.49		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	34.50		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	27.32		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	21.73		●	●	●	●	○	○	○	○	○	○	○	○	○

Q1d. ASQ-3 Total Score _____

Q1e. Do any scores require further monitoring and provision of learning activities?

Yes ☐ No ☐

Q1f. Do any scores suggest further assessment with a professional may be needed?

Yes ☐ No ☐

Comment: _____

Warwick Edinburgh Mental Wellbeing Scale

Q24. Score for WEMWS: _____

Note: may suggest need for EPDS if less than 48/49

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Actions/follow up:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____