

Six Month Visit Questionnaire

This questionnaire should be completed approx. six months 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: _____

Baby's Name: _____

Date Completed: _____

I agree for my responses to be used for evaluation purposes and understand that my information will be kept pseudonymised (i.e. my name, address, date of birth etc will not be shared and rather I will have a code that will be used to explore changes over time).

Any information presented will be anonymised :

Signature: _____

Date: _____

Signature: _____

Date: _____

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Family ID Number:

Date:

Mentor Initials:

Section One: Your Baby and Their Health

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

Six Month Visit Questionnaire

Family ID Number:

Date:

Mentor Initials:

Section One: Your Baby and their Health

How old is your baby now? _____

Q1. How many weeks pregnant were you when your baby was born? _____

Q2. How would you say your baby's health has been since birth?

Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Comments: _____

Q3a. Has your baby ever been taken to the GP, health centre, or to A&E for any health problems

Yes ☐ No ☐

Q3b. 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 baby? 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 baby 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 babies have accidents at some time. 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, SS16 Safe Rooms)

Yes ☐ No ☐

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

- 2 week checkup (usually with GP, in hospital or with midwife) ☐
- 6 week checkup (usually with GP or in hospital) ☐
- 3 months check (Usually Public health nurse) ☐
- None of the above ☐

Q7. Has baby 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)	
Other	Please Specify	

Baby'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)

Q8a. Approximately how many hours sleep does your baby have during (GUI 9 Months D3):

(a) the day? _____ (a) the night? _____ hours

Q8b. My baby sleeps the amount I expected (Infant Care Questionnaire)

Strongly Agree ☐ Agree ☐ Neither Agree nor Disagree ☐
Disagree ☐ Strongly Disagree ☐

Q8c. Does your baby sleep...

More than expected ☐

Less than expected ☐

As expected ☐

Section Two: The delivery

Q9. What weight was your baby when they were born?

_____ lbs _____ oz

Q10. What was the final mode of delivery?

Normal delivery ☐

Suction assisted birth ☐

Forceps assisted birth ☐

Planned/Elective Caesarean ☐

Emergency Caesarean ☐

Vaginal breech delivery ☐

Other (please specify) _____

Q11. Did your labour experience match your expectations?

Yes ☐ No ☐

Comments: _____

Q12. Did your baby have to go to a Neonatal Intensive Care Unit or Special Care Nursery after he/she was born?

Yes ☐ No ☐

Q13. Did baby need any help with his/her breathing from a ventilator?

Yes ☐ No ☐

Section Three: Baby's Diet

Q14. Have you tried to breastfeed this baby? *(include Colostrum in first few days after birth)*

Yes ☐ No ☐ (if no, go to Q18)

Q15. Were you breastfeeding when you brought him/her home from hospital

Yes ☐ No ☐

Q16. Was your baby ever exclusively breastfed? *(Exclusive breastfeeding means that the infant receives only breastmilk without any additional food or drink)*

Yes ☐ No ☐

Q16a. Was your baby ever exclusively breastfed when you brought him/her home from the hospital? *(Exclusive breastfeeding means that the infant receives only breastmilk without any additional food or drink)*

Yes ☐ No ☐

Q16b. If yes, how old was he/she when completely stopped being exclusively breastfed? (Accept answer in days or weeks or months)

_____ Days _____ Weeks _____ Months ☐ Still being exclusively breastfed

Q17. Are you currently breastfeeding? *(include partial/complementary breastfeeding)*

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

Yes ☐ (if yes, go to Q18) No ☐

Q17a. If no, how old was he/she when completely stopped being breastfed? (Accept answer in days or weeks or months)

_____ Days _____ Weeks _____ Months

Q17b. 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) _____ | | | |

Q18. Does baby drink anything else apart from milk or formula? (tick all that apply)

SS14 Teething; N14 Weaning to Solids; N19 Smart Drinks

- | | | | |
|------------------------------|--------------------------|---|--------------------------|
| Breastmilk/formula | ☐ | Fruit juices/cordial/squash | ☐ |
| Baby Juice | ☐ | Fizzy or soft drinks (E.g., lemonade, coke) | ☐ |
| Water | ☐ | Herbal drinks | ☐ |
| Tea | ☐ | Coffee | ☐ |
| Other (Please specify) _____ | | | |

Q19. 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 Q20)

Q19a. If yes, how old was baby when he/she first had solid food regularly? (Accept answer in days or weeks or months)

_____ Days _____ Weeks _____ Months

Q20. Have you every fed baby any of the following foods?

Infant cereal/rice ☐

Vegetables ☐

Fruits ☐

Meat ☐

Baby jars/sachets ☐

Other (please specify) _____



Section Four: Maternal Health

Q20. In general, how would you describe your health?

Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Comments:

Q21. Did you receive a check up six weeks post birth (with GP or in hospital)?

RR10 Pelvic Floor

Yes ☐ No ☐

Q22. Do you currently smoke?

	Yes	No
Cigarettes	☐	☐
Vaping	☐	☐

Q22a. If yes to cigarettes, about how many cigarettes per day do you usually smoke? _____

SS1 Smoking

Q22b. Does anyone else in your household currently smoke?

SS1 Smoking - Passive smoking

	Yes	No
Cigarettes	☐	☐
Vaping	☐	☐

Q23. Which of the following best describes how often you usually drink alcohol?

Never ☐ 3-4 times a week ☐
 Less than once a month ☐ 5-6 times a week ☐
 1-2 times a month ☐ Every day ☐
 1-2 times a week ☐

Q23a. If you currently drink alcohol between every day and 1-2 times a month ask:

In an average week, how many pints of beer/cider, glasses of wine, measures of spirit, and bottles of alcopops would you drink?

Pints of Beer/Cider	_____
Glasses of Wine	_____
Measures of Spirits	_____
Bottles of Alcopops	_____
Other:	_____

Q24. We would like to ask you about how you have been feeling over the last two weeks:

(Warwick Edinburgh Mental Wellbeing Scale) **PS12 Mood Swings & PND**

Please tick the box that best describes your experience of each over the last two weeks:

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Q25. We would like to ask you about your self care:

(HFPI- Self Care) **PS14 Adjusting & Support; PS18 Self-Care for Parents**

	Rarely or never	A little of the time	Some of the time	Good part of the time	Always or most of the time
I find ways to care for myself					
I take care of my appearance					
I get enough sleep					
I take time for myself					

Section Five: Support Network and Social Support

Your Support Network

Option to do my circles of support sheet if helpful

Q26. We would like to know about your support network: (HFPI- Social Support)

	Rarely or never	A little of the time	Some of the time	Good part of the time	Always or most of the time
I feel supported by others					
I feel that others care about me					
I discuss my feelings with someone					
If I have trouble, I feel there is always someone I can turn to for help					
I have family or friends who I can turn to for help					

Q27. How would you rate the support you are getting from the following?

	A lot of support	Some support	Little support	No support	Does not apply to me
From your spouse/partner					
From the baby's father (if different to spouse/partner)					
From your parents					
From other close relatives					
From friends					
Any other support networks (please specify here):					

Comments: _____

Q28a. Is anyone in your household working? (Refers to those over 18 only)

Note: NSP supports around employment and education

Yes ☐ No ☐ (if No, go to Q29)

Q28b. If Yes is this full /part time?

Yes ☐ No ☐ Not Applicable ☐

Comments: _____

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Q29. In terms of your financial situation, have you experienced any of the following over the last 12 months?

	Yes	No	N/A
Difficulty paying for weekly shop (e.g. food, household items, nappies, formula)			
Difficulty meeting rent or mortgage payments			
Difficulty keeping up to date with utility costs (e.g. electricity, heating, phone or internet)			
Struggling with back to school costs			
Struggling with other educational costs e.g. trips, extra resources, school collections for charities			
Struggling to afford childcare			
Affording essential baby items e.g. safe sleeping space, buggy, car seat, safety equipment			
Affording books and toys for children			
Affording appropriate amount/type of clothing needed for each family member			
Affording special occasions e.g. birthdays, Christmas, other cultural celebrations			
Keeping up with transport costs e.g. car payments, public transport costs			

Comments: _____

Q30. We would like to know how easy you would find it to access support if needed:

(HFPI- Mobilising Resources)

	Rarely or never	A little of the time	Some of the time	Good part of the time	Always or most of the time
I would know where to find resources for my family					
I would know where to find important medical information					
I could get help from the community if I needed it					
I would be comfortable in finding the help I need					
I would know community agencies (i.e. agencies that provide different types of support in the community) that I could go to for help					
It would be hard for me to ask for help from others					

Q31. TOPSE and Parenting Self Efficacy

Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10.

0	1	2	3	4	5	6	7	8	9	10
Completely disagree				Moderately agree						Completely agree

Emotion and Affection Statements SED6 Secure Base; RR2 Routine; RR3 Crying	Number
I am able to show affection towards my baby	
I can recognise when my baby is happy or sad	
I am confident my baby can come to me if they're unhappy	
When my baby is sad I understand why	
I have a good relationship with my baby	
I find it hard to cuddle my baby	
Play and Enjoyment Statements SED10 Confidence; CD3 Movement; CD4 Movement; CD5 Hand-eye Coordination; CD6 Reading with infants; CD7 Thinking & Learning; CD9 Reading Together; CD10 Playing to Learn; CD11 Books and Stories	
I am able to have fun with my baby	
I am able to enjoy each stage of my baby's development	
I am able to have nice days with my baby	
I can plan activities that my baby will enjoy	
Playing with my baby comes easily to me	
I am able to help my baby reach their full potential	
Empathy and Understanding Statements SED6 Secure Base; SED8 Communication & Mutual gaze; SED9 Regulation & Tired Signs; SED10 Confidence; CD2 Listening and Talking; CD8 Listening & Talking; CD18 Developing your child's language; RR2 Routine; RR3 Crying	
I am able to explain things patiently to my baby	
I can get my baby to listen to me	
I am able to comfort my baby	
I am able to listen to my baby	
I am able to put myself in my baby's shoes	
I understand my baby's needs	

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0	1	2	3	4	5	6	7	8	9	10
Completely disagree			Moderately agree				Completely agree			
Pressures Statements										Number
It is difficult to cope with other people's expectations of me as a parent										
I am not able to assert myself when other people tell me what to do with my baby										
Listening to other people's advice makes it hard for me to decide what to do										
I can say 'no' to other people if I don't agree with them										
I can ignore pressure from other people to do things their way										
I do not feel a need to compare myself to other parents										
Self Accepting Statements										
I know I am a good enough parent										
I can be strong for my baby										
My baby feels safe around me SED6 Secure Base										
Learning and Knowledge Statements SED11 Strangers ; CD1 Thinking & Learning ; CD3 Movement ; CD4 Movement ; CD5 Hand-eye coordination ; CD7 Thinking & Learning										
I am able to recognise developmental changes in my baby										
I am able to learn and use new ways of dealing with my baby										

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 HV Mentor.

Parent: _____

HV Mentor: _____

To be completed by Home Visitor at end:

Q32. Score for WEMWS: _____

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

Actions/follow up:

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