



Continuous Infant (Birth to 1 yr)

Visitor _____
ENVIRONMENT/SAFETY

Car seat?	(Y) Yes (X) <i>Don't Know/ Not Sure</i>	(N) No (R) <i>Refuse to Answer</i>	(Z) <i>Did not ask</i>
How often ride in car seat?	(A) Always (X) <i>Don't Know/ Not Sure</i>	(B) Often (R) <i>Refuse to Answer</i>	(C) Sometimes (Z) <i>Did not ask</i>
Sleep position?	(A) Side (X) <i>Don't Know/ Not Sure</i>	(B) Back (R) <i>Refuse to Answer</i>	(C) Stomach (Z) <i>Did not ask</i>
Co-sleeping?	(A) Always (X) <i>Don't Know/ Not Sure</i>	(B) Often (R) <i>Refuse to Answer</i>	(C) Sometimes (Z) <i>Did not ask</i>
Pillows/ toys?	(Y) Yes (X) <i>Don't Know/ Not Sure</i>	(N) No (R) <i>Refuse to Answer</i>	(Z) <i>Did not ask</i>

HEALTH

Medical Home Identified?	(Y) Yes (X) <i>Don't Know/ Not Sure</i>	(N) No (R) <i>Refuse to Answer</i>	(Z) <i>Did not ask</i>
Medical Home:			
Child disease?	(A) Autism (B) Diabetes (C) Asthma (D) Respiratory allergy (E) Cystic Fibrosis	(F) Food or digestive allergy (G) Eczema or any kind of skin allergy (H) Sickle Cell Anemia (I) Hearing or Speech Deficit (J) Other	(K) None of the Above (X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i> (Z) <i>Did not ask</i>
FROM MEDICAL RECORD: Immunizations 7 Months: 3 DTap, 3 Hep B, 2 IPV, at least 2 Hib	(A) Met (B) Unmet (C) Parent Refusal to Vaccinate Child (U) <i>Records Unavailable</i>	(W) <i>Not Applicable</i> (X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i> (Z) <i>Did not ask</i>	

NUTRITION

Currently breastfeeding?	(A) Yes, only breast milk (B) Yes, combination breast milk and formula (C) No	(X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i> (Z) <i>Did not ask</i>
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SUBSTANCE USE

Secondhand smoke exposure?	(A) None (B) Less than 1 hour	(C) 1-12 hours (D) 13-24 hours	(X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i> (Z) <i>Did not ask</i>
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DEVELOPMENT

Do you have any concerns about your child's learning, development, or behavior?	(Y) Yes (N) No	(X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i>	(Z) <i>Did not ask</i>
Have you been told by a medical provider that your child has a developmental delay?	(Y) Yes (N) No	(X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i>	(Z) <i>Did not ask</i>
ASQ 4 months	(A) Appropriate Development (B) Delayed	(C) Not Done	(W) Not Applicable
ASQ 8 months	(A) Appropriate Development (B) Delayed	(C) Not Done	(W) Not Applicable

FAMILY STRENGTHS

Primary Caregiver?	(A) Mother (B) My husband or partner (C) Baby's grandparent (D) Other close family member	(E) Friend or neighbor (F) Babysitter, nanny, or other child care provider (G) Staff at day care center	(H) Other (X) <i>Don't Know/ Not Sure</i> (R) <i>Refuse to Answer</i> (Z) <i>Did not ask</i>
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