Health check-up for 4 months old

Address: _____

_____

Name of infant: _____

Name of caregiver: _____

Telephone number: _____

Cellphone number: _____
(Mother/Father/Other)

Date of birth: _____ ____ ____ (*YYYYMMDD*)

Birth weight: _____

Gestation period: _____ weeks

Birth order: _____ child (e.g. 1st/2nd)

Caregiver (daytime hours):

Mother / Father / Grandmother / Grandfather / Daycare Center ( ) / Other ( )

Family Structure	Relationship	Age	Employed	Relationship	Age	Employed	Relationship	Age	Employed
			Yes / No			Yes / No			Yes / No
			Yes / No			Yes / No			Yes / No

Please circle ○ your selected answers.

1) If you have any concerns about your child's recent condition, body, or have concerns regarding parenting, etc. please write these in the below space.

2) After childbirth, has your child experienced any illnesses? Yes* / No

*Yes**: ① When: (approx. months old)

② Name of illness: (Spasms/Other:)

3) Please answer the following questions about raising your child. Please circle the number(s) that apply and write details in the blank spaces.

1) Is their head stable when held upright? Yes (from months old) / No / Not sure

2) When crawling on their stomach, do they raise their head? Yes (from months old) / No / Not sure

3) If you give them a rattle do they grip it? Yes (from months old) / No / Not sure

4) When lying on their back, do they put their hands together or lick their hands? Yes (from months old) / No / Not sure

5) Do they respond to voices or sounds? Yes (from months old) / No / Not sure

6) Do they follow a moving object with their eyes? Yes (from months old) / No / Not sure

7) When you look at them, do they look back and smile? Yes (from months old) / No / Not sure

8) Do they make sounds, such as groans and saying "Ah"? Yes (from months old) / No / Not sure

9) Are they usually in a good mood? Yes / No / Not sure

10) Do they often cry and need a lot of help? Yes / No / Not sure

11) Have they ever felt difficult to hold? Yes / No / Not sure

12) Approximately how often do they have bowel movements? ( ) times / ( ) day(s)

4) **Please answer the following about your child's daily nutrition.**

・Breastmilk (　　) times/day ・Milk (　　) ml x (　　) times

・Fruit Juice (　　) spoon/s ・Soup (　　) spoon/s ・Rice porridge (soft) (　　) spoon/s

・Hot water, tea etc. (　　)

5) Please answer the following questions about your child's mother.

1) Did you have any problems during pregnancy? No / Yes (　　)

2) Did you have any problems during childbirth? No / Yes (　　)

3) Did you feel unwell after childbirth, or have any problems show up when examined? No / Yes (　　)

4) Do you often talk to/interact with your child? Yes / No

5) Do you often have days when you feel down/unmotivated? No / Yes

6) Is there someone nearby in the community that you can talk to about your child, etc.? Yes / No

6) Please answer the following questions about parenting.

1) Is there somewhere outdoors in the community you can feel free to take your child to? Yes (　　) / No

2) Are there times when you find it difficult or tiring to raise your child? No / Sometimes / Often / Daily

What situations cause this: (　　)

3) Do you feel stress from the everyday tasks of raising your child? Yes* / No

**Yes:* Do you have ways to relieve this stress? Yes / No

4) Do you have someone close who can listen to you or help you out? Yes* / No

**Yes:* ① Who are they: (　　)

② What kind of help do they provide: (　　)

7. Please provide a brief summary of your child's daily routine. Please only fill in the parts that apply.

		(Sleep, Breast-feeding, Bathing, etc.)
Morning	0	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
Afternoon	12	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	

Example

		(Sleep, Breast-feeding, Bathing, etc.)
Morning	0	
	1	Feed
	2	Nap
	3	
	4	
	5	
	6	
	7	Feed
	8	Nap
	9	
	10	Walk
	11	
Afternoon	12	Feed
	1	Nap
	2	
	3	
	4	Feed
	5	Nap
	6	
	7	
	8	
	9	Bath
	10	Feed
	11	Sleep

The following is a survey from the Ministry of Health, Labor and Welfare's Healthy Parenting 21 (2nd phase). Thank you for your cooperation.

1. In the month or so following childbirth (and being discharged from the hospital), did you receive sufficient guidance and/or care from midwives/health workers? **Yes / No / Neither agree nor disagree**
2. Did you (mother) smoke while pregnant? **No / Yes (cigarettes per day)**
3. 1) Do you (mother) currently smoke? **No / Yes (cigarettes per day)**
   2) Does your child's father currently smoke? **No / Yes (cigarettes per day)**
4. Did you (mother) drink alcohol while pregnant? **No / Yes**
5. Which kind of nutrition did your child receive for the first month? **Breast milk / Milk formula / A mixture of both**
6. Would you like to continue to raise your child in this community?
   Yes, I want to / I think I'd prefer to / I think I'd rather not / No, I dont want to
7. Does your child's father help raise your child?
   Yes, he does / He sometimes does / He doesn't do much / Not sure
8. Do you (mother) feel that you have leisurely time to spend with your child? **Yes / No / Its hard to say**
9. Do you find it difficult to raise your child? **I always do / I sometimes do / I don't find it difficult**
   When you find it difficult, do you have ways to receive advice and/or solve these difficulties? **Yes / No**
10. Do you know that most children between the ages of 6 to 12 months try to follow what their parents do?
    Yes / No
11. In the past few months, have any of the following things happened in your family? Please circle all that apply.
    Excessive discipline / Child was violently hit / Infant was left home alone / Child was not fed for a long period / Yelled at the child in a strong tone / Shut the child's mouth / The child was shaken violently / None of these apply
12. Are you aware that babies can get brain damage from being shaken back and forth violently to the point that their head wobbles, known as Shaken Baby Syndrome (for example, if shaken because they won't stop crying no matter what)? **Yes / No**
13. Are you aware of the Telephone Consultation for Children's Emergency Care (#8000)? **Yes / No**
14. Does your child have an assigned family doctor? **Yes / No / Not sure**
15. Did you (the child's mother) work while pregnant? **Did work / Did not work**
    Do you feel that your workplace gave any consideration to your pregnancy while you continued to work? **Yes / No**
16. Are you aware of the "Maternity Mark"? **I am not / I am**
    Have you ever used the Maternity Mark by attaching it to yourself? **Yes, I have / No, I haven't**