

Developmental Milestones Checklist *

Child's Name _____ DOB _____

2 - 4 Weeks

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Responds to sounds by startling, blinking, crying, quieting, or breathing <input type="checkbox"/> Looks at face and follows with eyes <input type="checkbox"/> Responds to parent's face and voice <input type="checkbox"/> Moves arms, legs, and head <input type="checkbox"/> On stomach, lifts head momentarily | <ul style="list-style-type: none"> <input type="checkbox"/> Flexed posture <input type="checkbox"/> Can sleep for three or four hours at a time <input type="checkbox"/> Can stay awake for one hour or longer <input type="checkbox"/> When crying, can be consoled most of the time, by being spoken to or held |
|--|---|

Date _____ Signature _____

2 Months

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Coos and vocalizes reciprocally <input type="checkbox"/> Pays attention to voices, other sounds, sights <input type="checkbox"/> Smiles responsively <input type="checkbox"/> Shows pleasure with parents | <ul style="list-style-type: none"> <input type="checkbox"/> Lifts head, neck, and upper chest with support of forearms while on stomach <input type="checkbox"/> Has some control in upright position |
|---|---|

Date _____ Signature _____

4 Months

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Babbles and coos <input type="checkbox"/> Smiles, laughs, and squeals <input type="checkbox"/> On stomach, holds head erect and raises body on hands <input type="checkbox"/> Rolls over from stomach to back | <ul style="list-style-type: none"> <input type="checkbox"/> Opens hands, holds own hands, grasps rattle <input type="checkbox"/> Good head control <input type="checkbox"/> Reaches for and bats objects <input type="checkbox"/> Recognizes parent's voice and touch |
|---|---|

Date _____ Signature _____

6 Months

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Babbles reciprocally <input type="checkbox"/> Says "dada" or "baba" <input type="checkbox"/> When pulled to sit, has no head lag <input type="checkbox"/> Sits with support <input type="checkbox"/> Stands when placed <input type="checkbox"/> Grasps and mouths objects <input type="checkbox"/> Shows differential recognition of parents | <ul style="list-style-type: none"> <input type="checkbox"/> Transfers cubes from hand to hand <input type="checkbox"/> Rakes in small objects <input type="checkbox"/> Self-comforts <input type="checkbox"/> Smiles, laughs, squeals, imitates razzing noise <input type="checkbox"/> Turns to sound <input type="checkbox"/> May have first tooth |
|--|---|

Date _____ Signature _____

9 Months

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Responds to own name <input type="checkbox"/> Understands a few words <input type="checkbox"/> Babbles <input type="checkbox"/> Crawls, creeps, or scoots <input type="checkbox"/> Sits unsupported | <ul style="list-style-type: none"> <input type="checkbox"/> Piles with fingers, shakes, bangs, throws, drops objects <input type="checkbox"/> Plays peek-a-boo or pat-a-cake <input type="checkbox"/> Feeds self with fingers <input type="checkbox"/> May show anxiety with strangers |
|--|--|

Date _____ Signature _____

Reference: Bright Futures

*Note: This resource is not a standardized, validated screening tool.

EPDS

Name: _____

Date: _____ Baby's Age: _____

As you have recently had a baby, we would like to know how you are feeling. Please mark the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Here is an example.

I have felt happy:

- Yes, all the time
- Yes, most of the time
- No, not very often
- Not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things.

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things.

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

3. * I have blamed myself unnecessarily when things went wrong.

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4. I have been anxious or worried for no good reason.

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

5. * I have felt scared or panicky for not very good reason.

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

6. * Things have been getting on top of me.

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

7. * I have been so unhappy that I have had difficulty sleeping.

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

8. * I have felt sad or miserable.

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

9. * I have been so unhappy that I have been crying.

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

10. * The thought of harming myself has occurred to me.

- Yes, quite often
- Sometimes
- Hardly ever
- Never