SWYC™: 2 months

1 months, 0 days to 3 months, 31 days

V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Makes sounds that let you know he or she is happy or upset	0	1	2
Seems happy to see you	0	1	2
Follows a moving toy with his or her eyes	0	1	2
Turns head to find the person who is talking	0	1	2
Holds head steady when being pulled up to a sitting position	0	1	2
Brings hands together	0	1	2
Laughs	0	1	2
Keeps head steady when held in a sitting position	0	1	2
Makes sounds like "ga," "ma," or "ba"	0	1	2
Looks when you call his or her name	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Ⓨ	Ⓝ
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Ⓨ	Ⓝ
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Ⓨ	Ⓝ
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Ⓨ	Ⓝ

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

6 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
7 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

8 During the past week, how many days did you or other family members read to your child? Ⓞ Ⓛ Ⓦ Ⓧ Ⓨ Ⓩ Ⓐ Ⓑ

*EMOTIONAL CHANGES WITH A NEW BABY***

Since you have a new baby in your family, we would like to know how you are feeling now. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past seven days…

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 no 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

SWYC™: 4 months

4 months, 0 days to 5 months, 31 days

V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Holds head steady when being pulled up to a sitting position	0	1	2
Brings hands together	0	1	2
Laughs	0	1	2
Keeps head steady when held in a sitting position	0	1	2
Makes sounds like "ga," "ma," or "ba"	0	1	2
Looks when you call his or her name	0	1	2
Rolls over	0	1	2
Passes a toy from one hand to the other	0	1	2
Looks for you or another caregiver when upset	0	1	2
Holds two objects and bangs them together	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

PARENT'S CONCERNS

	Not at all	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Ⓨ	Ⓝ
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Ⓨ	Ⓝ
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Ⓨ	Ⓝ
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Ⓨ	Ⓝ

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

6 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
7 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

8 During the past week, how many days did you or other family members read to your child?

Ⓞ Ⓛ Ⓦ Ⓧ Ⓨ Ⓩ Ⓐ Ⓑ

*EMOTIONAL CHANGES WITH A NEW BABY***

Since you have a new baby in your family, we would like to know how you are feeling now. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past seven days…

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 no 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

SWYC™: 6 months

6 months, 0 days to 8 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Makes sounds like "ga," "ma," or "ba"	0	1	2
Looks when you call his or her name	0	1	2
Rolls over	0	1	2
Passes a toy from one hand to the other	0	1	2
Looks for you or another caregiver when upset	0	1	2
Holds two objects and bangs them together	0	1	2
Holds up arms to be picked up	0	1	2
Gets into a sitting position by him or herself	0	1	2
Picks up food and eats it	0	1	2
Pulls up to standing	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

PARENT'S CONCERNS

	Not at all	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	◯	◯	◯
Do you have any concerns about your child's behavior?	◯	◯	◯

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Ⓨ	Ⓝ
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Ⓨ	Ⓝ
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Ⓨ	Ⓝ
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Ⓨ	Ⓝ

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

6 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
7 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

8 During the past week, how many days did you or other family members read to your child? Ⓞ ① ② ③ ④ ⑤ ⑥ ⑦

*EMOTIONAL CHANGES WITH A NEW BABY***

Since you have a new baby in your family, we would like to know how you are feeling now. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past seven days…

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

Ⓞ As much as I always could | ① Not quite so much now | ② Definitely not so much now | ③ Not at all

2 I have looked forward with enjoyment to things

Ⓞ As much as I ever did | ① Rather less than I used to | ②Definitely less than I used to | ③ Hardly at all

3* I have blamed myself unnecessarily when things went wrong

③ Yes, most of the time | ② Yes, some of the time | ① Not very often | Ⓞ No, never

4 I have been anxious or worried for no good reason

Ⓞ No, not at all | ① Hardly ever | ② Yes, sometimes | ③ Yes, very often

5* I have felt scared or panicky for no good reason

③ Yes, quite a lot | ② Yes, sometimes | ① No, not much | Ⓞ No, not at all

6* Things have been getting on top of me

③ Yes, most of the time I haven't been able to cope at all | ② Yes, sometimes I haven't been coping as well as usual | ① 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

③ Yes, most of the time | ② Yes, sometimes | ① Not very often | Ⓞ No, not at all

8* I have felt sad or miserable

③ Yes, most of the time | ② Yes, quite often | ① Not very often | Ⓞ No, not at all

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

③ Yes, most of the time | ② Yes, quite often | ① Only occasionally | Ⓞ No, never

10* The thought of harming myself has occurred to me

③ Yes, quite often | ② Sometimes | ① Hardly ever | Ⓞ Never

SWYC™: 9 months

9 months, 0 days to 11 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Holds up arms to be picked up	0	1	2
Gets into a sitting position by him or herself	0	1	2
Picks up food and eats it	0	1	2
Pulls up to standing	0	1	2
Plays games like "peek-a-boo" or "pat-a-cake"	0	1	2
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	0	1	2
Copies sounds that you make	0	1	2
Walks across a room without help	0	1	2
Follows directions - like "Come here" or "Give me the ball"	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 12 months

12 months, 0 days to 14 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Picks up food and eats it	0	1	2
Pulls up to standing	0	1	2
Plays games like "peek-a-boo" or "pat-a-cake"	0	1	2
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	0	1	2
Copies sounds that you make	0	1	2
Walks across a room without help	0	1	2
Follows directions - like "Come here" or "Give me the ball"	0	1	2
Runs	0	1	2
Walks up stairs with help	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC:™ 15 months

15 months, 0 days to 17 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	0	1	2
Copies sounds that you make	0	1	2
Walks across a room without help	0	1	2
Follows directions - like "Come here" or "Give me the ball"	0	1	2
Runs	0	1	2
Walks up stairs with help	0	1	2
Kicks a ball	0	1	2
Names at least 5 familiar objects - like ball or milk	0	1	2
Names at least 5 body parts - like nose, hand, or tummy	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 18 months

18 months, 0 days to 22 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Runs	0	1	2
Walks up stairs with help	0	1	2
Kicks a ball	0	1	2
Names at least 5 familiar objects - like ball or milk	0	1	2
Names at least 5 body parts - like nose, hand, or tummy	0	1	2
Climbs up a ladder at a playground	0	1	2
Uses words like "me" or "mine"	0	1	2
Jumps off the ground with two feet	0	1	2
Puts 2 or more words together - like "more water" or "go outside"	0	1	2
Uses words to ask for help	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	○	○	○	○	○

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	○	○	○	○	○
When you say a word or wave your hand, will your child try to copy you?	○	○	○	○	○
Does your child look at you when you call his or her name?	○	○	○	○	○
Does your child look if you point to something across the room?	○	○	○	○	○

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	No tension ○	Some tension ○	A lot of tension ○	Not applicable ○
9 Do you and your partner work out arguments with:	No difficulty ○	Some difficulty ○	Great difficulty ○	Not applicable ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 24 months

23 months, 0 days to 28 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Names at least 5 body parts - like nose, hand, or tummy	0	1	2
Climbs up a ladder at a playground	0	1	2
Uses words like "me" or "mine"	0	1	2
Jumps off the ground with two feet	0	1	2
Puts 2 or more words together - like "more water" or "go outside"	0	1	2
Uses words to ask for help	0	1	2
Names at least one color	0	1	2
Tries to get you to watch by saying "Look at me"	0	1	2
Says his or her first name when asked	0	1	2
Draws lines	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

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********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	○	○	○	○	○

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	○	○	○	○	○
When you say a word or wave your hand, will your child try to copy you?	○	○	○	○	○
Does your child look at you when you call his or her name?	○	○	○	○	○
Does your child look if you point to something across the room?	○	○	○	○	○

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	No tension ○	Some tension ○	A lot of tension ○	Not applicable ○
9 Do you and your partner work out arguments with:	No difficulty ○	Some difficulty ○	Great difficulty ○	Not applicable ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 30 months

29 months, 0 days to 34 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Names at least one color	0	1	2
Tries to get you to watch by saying "Look at me"	0	1	2
Says his or her first name when asked	0	1	2
Draws lines	0	1	2
Talks so other people can understand him or her most of the time	0	1	2
Washes and dries hands without help (even if you turn on the water)	0	1	2
Asks questions beginning with "why" or "how" - like "Why no cookie?"	0	1	2
Explains the reasons for things, like needing a sweater when it's cold	0	1	2
Compares things - using words like "bigger" or "shorter"	0	1	2
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

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********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	○	○	○	○	○

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	○	○	○	○	○
When you say a word or wave your hand, will your child try to copy you?	○	○	○	○	○
Does your child look at you when you call his or her name?	○	○	○	○	○
Does your child look if you point to something across the room?	○	○	○	○	○

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	No tension ○	Some tension ○	A lot of tension ○	Not applicable ○
9 Do you and your partner work out arguments with:	No difficulty ○	Some difficulty ○	Great difficulty ○	Not applicable ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 36 months

35 months, 0 days to 46 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Talks so other people can understand him or her most of the time	0	1	2
Washes and dries hands without help (even if you turn on the water)	0	1	2
Asks questions beginning with "why" or "how" - like "Why no cookie?"	0	1	2
Explains the reasons for things, like needing a sweater when it's cold	0	1	2
Compares things - using words like "bigger" or "shorter"	0	1	2
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	0	1	2
Tells you a story from a book or tv	0	1	2
Draws simple shapes - like a circle or a square	0	1	2
Says words like "feet" for more than one foot and "men" for more than one man	0	1	2
Uses words like "yesterday" and "tomorrow" correctly	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 48 months

47 months, 0 days to 58 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Compares things - using words like "bigger" or "shorter"	0	1	2
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	0	1	2
Tells you a story from a book or tv	0	1	2
Draws simple shapes - like a circle or a square	0	1	2
Says words like "feet" for more than one foot and "men" for more than one man	0	1	2
Uses words like "yesterday" and "tomorrow" correctly	0	1	2
Stays dry all night	0	1	2
Follows simple rules when playing a board game or card game	0	1	2
Prints his or her name	0	1	2
Draws pictures you recognize	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

SWYC™: 60 months

59 months, 0 days to 65 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Tells you a story from a book or tv	0	1	2
Draws simple shapes - like a circle or a square	0	1	2
Says words like "feet" for more than one foot and "men" for more than one man	0	1	2
Uses words like "yesterday" and "tomorrow" correctly	0	1	2
Stays dry all night	0	1	2
Follows simple rules when playing a board game or card game	0	1	2
Prints his or her name	0	1	2
Draws pictures you recognize	0	1	2
Stays in the lines when coloring	0	1	2
Names the days of the week in the correct order	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

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********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7