Study Specific Number

The First 1,000 Days of Life

Second Survey

APPROVED: Inova IRB
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Infant Nutrition

1. In the past 7 days, how often was your baby fed each food listed below? Include feedings by everyone who feeds the baby and include snacks and night-time feedings.

(Please put ZERO in the column if your baby was not fed any of foods listed below.)

	Per week	Per day
Breast milk		
Water		
Formula		
Cow's milk		
Soy milk, rice milk, goat milk		
100% fruit or 100% vegetable juice		
Juice drinks, soft drinks, sweet tea, Kool Aid, vitamin drinks, etc		
Baby cereal		
Dairy foods: yogurt, cheese, ice cream, pudding, etc.		
Soy foods: tofu, frozen soy desserts, etc.		
Other cereals and starches: breakfast cereals		
biscuits, crackers, breads, pasta, rice, etc		
Eggs		
Vegetables		
Fruit		
Meat, chicken, combination dinners		
Fish or shellfish		
Peanut butter, other peanut foods, or nuts		
French fries		
Sweet foods: candy, cookies, cake, etc		
Other (Please specify)		

2. Are there any difficulties with feeding your baby?

a. Yes b. No c. Not Sure

2a. If yes, please specify:

a. Too slow b. Too fast c. Choking d. Colic e. Reflux f. Spitting g. Other

Infant Growth & Development

3. How much does your baby weigh? ----- lb -----oz

4. How tall is your baby? -------inches

5. When was the last time your baby was weighed?

   a. Within the past week b. Within the past two weeks
   c. More than two weeks ago d. Not sure

6. Where was the last time your baby was weighed?

   a. Medical office/clinic b. Home c. Not sure d. Other

7. Do you have concerns about your baby's weight?

   a. Yes b. No c. Not sure

8. What kind of health problems does your child have?

   a. Ear infections b. Colds c. Vomiting d. Anemia e. Constipation/Diarrhea
   f. Asthma g. Skin problems/ Allergies h. Developmental concern i. None j. Other
   If other please specify: ☐

9. Has your baby been diagnosed with any medical condition or disorder?

   a. Yes b. No c. Not sure

10. Do you have concerns with your child's health?

    a. Yes b. No c. Not sure

11. Have you made a visit to the baby's doctor for your child being sick or injured?
    (Please do not include routine well baby visit)

    a. Yes b. No c. Not sure

11a. If yes, how many times?

    a. 0-2 b. 3-6 c. more than 6 times

12. Has your child received all the recommended immunizations?

    a. Yes b. No c. Not sure

12a. If no, why?

    a. Appointment was delayed b. Vaccine safety concerns

13. Is your baby currently taking any prescribed medication?
    a. Yes b. No c. Not sure

14. Does your baby take any “over-the-counter” medications on a regular basis?

a. Yes b. No c. Not sure

15. Is your child regularly being cared for outside of your home?

a. Yes b. No c. Not sure

15a. If yes, are you satisfied with the child care that you have?

a. Yes b. No c. Not sure

16. Does your baby sleep for at least one four hour stretch at night?

a. Yes b. No c. Not sure

17. Does your baby cry a lot?

a. Rarely b. Occasionally c. Sometimes d. Usually e. Very Often

18. Do you use a television to help your baby sleep?

a. Yes b. No c. Sometimes

19. Do you have the television on while your baby is eating?

a. Yes b. No c. Sometimes

20. How much time each day does your baby spend:

a. With the television or a video **on** in the home (including daycare)?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

b. Looking at or playing with a computer or tablet/smartphone?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

c. Playing outside time?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

d. Being read to?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

CSBS-DP

This Checklist is designed to identify different aspects of development in infants and toddlers. Many behaviors that develop before children talk may indicate whether or not a child will have difficulty learning to talk. This Checklist should be completed by a caregiver when the child is between **6 and 24 months of age** to determine whether a referral for an evaluation is needed. The caregiver may be either a parent or another person who nurtures the child daily. Please check all the choices that best describe your child's behavior. If you are not sure, please choose the closest response based on your experience.

Children at your child's age are not necessarily expected to use all the behaviors listed.

Emotion and Eye Gaze

1. Do you know when your child is happy and when your child is upset?
□Not Yet □ Sometimes □ Often

2. When your child plays with toys, does he/she look at you to see if you are watching?
□Not Yet □ Sometimes □ Often

3. Does your child smile or laugh while looking at you?
□Not Yet □ Sometimes □ Often

4. When you look at and point to a toy across the room, does your child look at it?
□Not Yet □ Sometimes □ Often

Communication

5. Does your child let you know that he/she needs help or wants an object out of reach?
□Not Yet □ Sometimes □ Often

6. When you are not paying attention to your child, does he/she try to get your attention?
□Not Yet □ Sometimes □ Often

7. Does your child do things just to get you to laugh?
□Not Yet □ Sometimes □ Often

8. Does your child try to get you to notice interesting objects—just to get you to look at the objects, not to get you to do anything with them?
□Not Yet □ Sometimes □ Often

Gestures

9. Does your child pick up objects and give them to you?
□Not Yet □ Sometimes □ Often

10. Does your child show objects to you without giving you the object?
□Not Yet □ Sometimes □ Often

11. Does your child wave to greet people?
□Not Yet □ Sometimes □ Often

12. Does your child point to objects?
□Not Yet □ Sometimes □ Often

13. Does your child nod his/her head to indicate *yes*?
□Not Yet □ Sometimes □ Often

Sounds

14. Does your child use sounds or words to get attention or help?
□Not Yet □ Sometimes □ Often

15. Does your child string sounds together, such as *uh oh, mama, gaga, bye bye, bada*?
□Not Yet □ Sometimes □ Often

16. About how many of the following consonant sounds does your child use:
ma, na, ba, da, ga, wa, la, ya, sa, sha?
□ None □1–2 □ 3–4 □ 5–8 □ over 8

Words

17. About how many different words does your child use meaningfully that you recognize (such as *baba* for bottle; *gaggie* for doggie)?
□None □ 1–3 □ 4–10 □11–30 □over 30

18. Does your child put two words together (for example, *more cookie*, *bye bye Daddy*)?
□Not Yet □ Sometimes □ Often

Understanding

19. When you call your child's name, does he/she respond by looking or turning toward you?
□Not Yet □ Sometimes □ Often

20. About how many different words or phrases does your child understand without gestures? For example, if you say "where's your tummy," "where's Daddy," "give me the ball," or "come here," without showing or pointing, your child will respond appropriately.
□ None □ 1–3 □ 4–10 □ 11–30 □over 30

Object Use

21. Does your child show interest in playing with a variety of objects?
□Not Yet □ Sometimes □ Often

22. About how many of the following objects does your child use appropriately:
cup, bottle, bowl, spoon, comb or brush, toothbrush, washcloth,
ball, toy vehicle, toy telephone?
□ None □1–2 □ 3–4 □ 5–8 □ over 8

23. About how many blocks (or rings) does your child stack?
□ None □ 2 blocks □ 3–4 blocks □5 or more

24. Does your child pretend to play with toys (for example, feed a stuffed animal, put a doll to sleep, put an animal figure in a vehicle)?
□Not Yet □ Sometimes □ Often

26. Do you have any concerns about your child's development?
□ yes □ no

If yes, please describe:

Developmental Milestones

Please indicate if your child is doing any of these activities:

	YES	NO
1.Takes objects out of container		
2.Claps hands		
3.Drinks from a cup with help		
4.Stands momentarily		
5.Walks with one hand held		
6.Understands names of familiar people and objects		
7.Says a few words		
8.Responds to a firm "No"		
9.Shows anxiety when separated from primary caregiver		

Parent-Child Interactions Scale

1. I play with my child and show him or her things about toys.	Not very often	Sometimes	Often
2. I hug and kiss my child.	Not very often	Sometimes	Often
3. I mostly talk to my child when he is crying.	Not very true	Sometimes true	Mostly true
4. I help my child learn by talking and showing him or her new things.	Not very true	Sometimes true	Mostly true
5. I look at or read children's books to my child.	Not very often	Sometimes	Often
6. My child does not calm down or seem very interested when I talk to him.	Mostly true	Sometimes true	Not very true
7. I make up games or songs for my child.	Not very often	Sometimes	Often
8. When my child looks at or touches a toy, I talk to him about the toy.	Not very often	Sometimes	Most of the time
9. When my child is looking at me, I talk or make sounds with him.	Not very often	Sometimes	Often
10. My child doesn't seem to like me.	Mostly true	Sometimes true	Not very true
11. I enjoy feeding my child or eating with him.	Not very often	Sometimes	Often
12. I talk to my child in a special way.	Not very often	Sometimes	Often
13. My child is not very much fun to be with.	Mostly true	Sometimes true	Not very true
14. I can make my child feel better when he or she is upset.	Not very often	Sometimes	Often
15. When my child looks at or touches something, the first thing I say is "no."	Mostly true	Sometimes true	Not very true
16. Most of the time I like my child.	Not very true	Sometimes true	Mostly true
17. My child does not need my help learning new things.	Mostly true	Sometimes true	Not very true
18. I talk with my child when feeding or eating with him or her.	Not very often	Sometimes	Most of the time

Maternal Confidence Scale

How confident do you feel in your parenting role? **(Check appropriate box)**

	Never	Seldom	Sometimes	Often	Always
1. I know when my baby wants me to play with him/her.					
2.I know how to take care of my baby better than anyone else.					
3.When my baby is cranky, I know the reason.					
4.I can tell when my baby is tired and needs to sleep.					
5. I know what makes my baby happy.					
6.I can give my baby a bath.					
7.I can feed my baby adequately.					
8.I can hold my baby properly.					
9.I can tell when my baby is sick.					
10.I feel frustrated taking care of my baby.					
11.I would be good at helping other mothers learn how to take care of their infants.					
12. Being a parent is demanding and unrewarding.					
13.I have all the skills needed to be a good parent.					
14.I am satisfied with my role as a parent.					

Prime-MD PHQ 2

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
   □Yes □No
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

   □Yes □No

If you answered **NO** to both of the above questions, please skip the following questions and continue with **Perceived Stress Scale**

. If you answered **YES** to either question, please complete the 10 statements, below.

Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

EPDS

Here is an example, already completed.

I have felt happy:

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

If you selected the second option, 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

If you have any serious concerns about your mental health,

please call **211** and request a referral for assistance.

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to check the column indicating *how often* you felt or thought a certain way.

	Never	Almost Never	Some-times	Fairly Often	Often
1. In the last month, how often have you been upset because of something that happened unexpectedly?					
2. In the last month, how often have you felt that you were unable to control the important things in your life?					
3. In the last month, how often have you felt nervous and "stressed"?					
4. In the last month, how often have you felt confident about your ability to handle your personal problems?					
5. In the last month, how often have you felt that things were going your way?					
6. In the last month, how often have you found that you could not cope with all the things that you had to do?					
7. In the last month, how often have you been able to control irritations in your life?					
8. In the last month, how often have you felt that you were on top of things?					
9. In the last month, how often have you been angered because of things that were outside of your control?					
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?					

Is there anything more you would like to tell us about **you and your baby?**

References

Some of questions have been adopted and modified from CDC.

CSBSDP
Communication and Symbolic Behavior Scales Developmental Profile by Amy M. Wetherby & Barry M. Prizant
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Parent-Child Interactions Survey
Frances Page Glascoe, Parent-Child Interactions Scale. From Brigance A and Glascoe FP. Brigance Infant toddler Screens. North Billerica, MA: Curriculum Associates, 2002 www.curriculumassociates.com. The publisher gives permission for the scales to be used as long as the above is cited

Maternal Confidence Scale
Zahr L. The relationship between maternal confidence and mother-infant behaviors in premature infants. *Research in Nursing & Health* 1991; 14(4)279–286.
Prime-MD PHQ 2
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

EPDS
1 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .
2 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002,194-199

Perceived Stress Scale
The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 386-396.
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The rest of questions have been developed by Inova Translational Medicine Institute research team.