Study Specific Number

The First 1,000 Days of Life

18 Months Survey

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Infant Nutrition

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

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

	Times	Per week *OR* 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			
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. Does your child eat fast food (e.g. fries and hamburger) a. Yes b. No

If yes how many times a week? ----------

3. Does your child have allergy to any food?
a. Yes b. No c. Not sure
3a. If yes , please select: Itching b. Nausea c. Vomiting d. Bloody diarrhea e. Abdominal pain f. Hives g. Eczema

4. Are there any difficulties with feeding your child?

a. Yes b. No c. Not Sure

4. a. If yes, please specify:

a. Picky eater b. Does not eat enough c. Choking d. Reflux e. Spitting
f. Other

Infant Growth & Development

5. How much does your child weigh? ----- lb -----oz

6. How tall is your child? ----- inches

7. When was the last time your child was weighed/ measured?

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

8. Where was your child weighed/ measured?

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

9. Do you have concerns about your child's weight?

a. Yes b. No c. Not sure

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

a. Yes b. No c. Not sure

10a. If yes, how many times in the past six months?

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

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

a. Yes b. No c. Not sure

12. Does your child have any health problems? a. Yes b. No

12a. If Yes:

a. Ear infections b. Colds c. Upper respiratory d. Wheezing
e. Vomiting f. Seizures g. Constipation/Diarrhea h. Eczema i. Allergies
j. Developmental concern k. Iron deficiency
l. Other Please specify

13. Has your child been diagnosed with any medical condition or disorder?

a. Yes b. No c. Not sure

13a. if yes:

a. Asthma b. Over weight c. Developmental delay d. Anemia e. Other

14. Has your child received all the recommended immunizations?

a. Yes b. No c. Not sure

14a. If no, why?

a. Appointment was delayed b. Vaccine safety concerns

15. Is your child currently taking any vitamin/supplement?

a. Yes b. No c. Not sure

16. Is your child currently taking any prescribed medication?

a. Yes b. No c. Not sure

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

a. Yes b. No c. Not sure

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

a. Yes b. No c. Not sure

18a. If yes, are you satisfied with the child care that you have?

a. Yes b. No c. Not sure

19. Does your child sleep all night?

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

20. How often does your child sleep in your bed?

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

21. Do you use television to help your child sleep?

a. Yes b. No c. Sometimes

22. Do you have the television on while your child is eating?

a. Yes b. No c. Sometimes

23. How much time each day does your child spend:

a. With the television or a video on in the home (including daycare)?
□None □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?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

c. Playing outside?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

d. Being read to?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

Dental

1. Have you started to clean your child's teeth as soon as the first tooth appeared?

   a. Yes b. No c. Not sure

2. Do you brush/clean your child's teeth twice a day?

   a. Yes b. No c. Not sure

Developmental Milestones

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

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

	Yes	No
Likes to hand things to others as play		
May have temper tantrums		
May be afraid of strangers		
Shows affection to familiar people		
Plays simple pretend, such as feeding a doll		
May cling to caregivers in new situations		
Points to show others something interesting		
Explores alone but with parent close by		
Says several single words		
Says and shakes head "no"		
Points to show someone what he/she wants		

Knows what ordinary things are for; for example, telephone, brush, spoon		
Points to get the attention of others		
Shows interest in a doll or stuffed animal by pretending to feed		
Points to one body part		
Scribbles on his/her own		
Can follow 1-step verbal commands without any gestures; for example, sits when you say “sit down”		
Walks alone		
May walk up steps and run		
Pulls toys while walking		
Can help undress herself/himself		
Drinks from a cup		
Eats with a spoon		

CSBS

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

Do you have any concerns about your child’s development?
□ Yes □ No

If yes, please describe:

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? ***(Use "✔" to indicate your answer)***	Not at all	Several days	More than half the days	Nearly every day
1. **Little interest or pleasure in doing things**	0	1	2	3
2. **Feeling down, depressed, or hopeless**	0	1	2	3
3. **Trouble falling or staying asleep, or sleeping too much**	0	1	2	3
4. **Feeling tired or having little energy**	0	1	2	3
5. **Poor appetite or overeating**	0	1	2	3
6. **Feeling bad about yourself — or that you are a failure or have let yourself or your family down**	0	1	2	3
7. **Trouble concentrating on things, such as reading the newspaper or watching television**	0	1	2	3
8. **Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual**	0	1	2	3
9. **Thoughts that you would be better off dead or of hurting yourself in some way**	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

If you have any serious concerns about your mental health,

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

MOS Social Support Survey

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? **(Circle one number on each line.)**

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/informational support					
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Tangible support					
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5
Affectionate support					
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5
Positive social interaction					
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Additional item					
Someone to do things with to help you get your mind off things	1	2	3	4	5

Life Orientation Test

Strongly Agree → Strongly Disagree

	A	B	C	D	E
1. In uncertain times I usually expect the best.					
2. It's easy for me to relax.					
3. If something can go wrong for me, it will.					
4. I'm always optimistic about my future.					
5. I enjoy my friends a lot.					
6. It's important for me to keep busy.					
7. I hardly ever expect things to go my way.					
8. I don't get upset too easily.					
9. I rarely count on good things happening to me.					
10. Overall, I expect more good things to happen to me than bad.					

Life Events Evaluation

Please select any events that have occurred in your life over the past 6 months:

- □ Personal health problems
- □ Personal social problems
- □ Problems with current partner
- □ Family disruption
- □ Problems with your finances
- □ Problems with your own children
- □ Problems with your in-laws
- □ Problems within your close family
- □ Serious illness in your close family
- □ Death within your close family
- □ Loss of job (you or your partner)
- □ Problems within your work environment
- □ Work transfer (you or your partner)
- □ Change in residence
- □ Problem in finding stable housing
- □ Current partner is away often
- □ Accidents, robberies, or similar events

Demographics

What is your marital status?

□ Single
□ Married
□ Divorced
□ Widowed
□ Legally Separated
□ Have a significant other
□ Other
□ Decline to answer

What is your education level?

□ Completed less than the 11 grade
□ High School Graduate/GED
□ Some College
□ Associate's Degree
□ Bachelor's Degree
□ Master's Degree
□ Doctorate Degree /Higher Level of Education

What is your Occupation?

□ Management, Professional, and Related Occupations
□ Service Occupations
□ Construction, Maintenance, Repair Occupations
□ Production, Transportation, Material Moving Occupations
□ Agricultural Occupations
□ Sales, Office Occupations
□ Homemaker
□ Decline to answer

Your annual household income from all sources:

□ Less than $25,000
□ $25,000 - $49,999
□ $50,000 - $74,999
□ $75,000 - $99,999
□ 100,000 - $149,999
□ $150,000 - $199,999
□ $200,000 - $249,999
□ Greater than $250,000
□ Don't know / Not sure
□ Decline to answer

Do you rent or own the housing you are currently living in?

□Rent or pay someone for housing
□Own my home
□Living with someone (no rent)

Including yourself, how many people currently live in your household (including those who live there on a part time basis)? _____

What is the ZIP Code where you live? _ _ _ _ _

□ Don‘t know / Not sure
□ Decline to answer

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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Medical Outcomes Study (MOS)Social Support Survey
The RAND Corporation, 1700 Main Street, Santa Monica, CA 90407-2138. U.S.A. and
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PHQ-9
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Life Orientation Test
Michael F. Scheier & Charles S. Carver. (1985). Optimism, coping, and health: Assessment and Implications of generalized outcome expectancies. *Health Psychology,* 4, 219-247

The rest of questions have been developed by Inova Translational Medicine Institute Research Team.