Study Specific Number

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The First 1,000 Days of Life … And Beyond

48 Months Survey

Child 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 Day *OR*	Per Week
Water			
Cow's milk - whole			
Cow's milk – low fat			
Cow's milk –fat free			
Other milk Products			
100% fruit or 100% vegetable juice			
Juice drinks, soft drinks, sweet tea, Kool Aid, vitamin drinks, etc			
Diet 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. Do you keep fresh fruits and vegetables available for your child?
   a. Yes b. No c. Not sure

4. Does your child have an allergy or bad reaction to any foods?
   a. Yes b. No c. Not sure

   4a. If yes , how did he/she react when was fed the problem food? Please select:

   a. Itching b. Nausea c. Vomiting d. Bloody diarrhea e. Abdominal pain f. Hives
   b. g. Eczema h. other:_____

5. Is your child a picky eater?

   a. Yes b. No c. Not Sure

Child Growth & Development

6. How much does your child weigh? _____ lb _____oz

7. How tall is your child? _____ inches

8. 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

9. Where was your child weighed/ measured?

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

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

    a. Yes b. No c. Not sure

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

    a. Yes b. No c. Not sure

11a. If yes, how many times in the past 12 months?

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

12. Has your child visited an urgent care or emergency department?
    Yes b. No c. Not sure

12a. If yes, how many times in the past 12 months?

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

13. Do you have concerns about your child's health?

a. Yes b. No c. Not sure

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

14a. If Yes (please check all that apply):

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. None m. Other Please specify

15. Has your child been diagnosed by a health care provider with a medical condition or disorder?

a. Yes b. No c. Not sure

15a. If yes, is there a diagnosis of:
a. Asthma b. Over weight c. Developmental delay d. Anemia e. Other

16. Has your child received all the recommended immunizations?

a. Yes b. No c. Not sure

16a. If no, why?

a. Appointment was delayed b. Vaccine safety concerns

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

a. Yes b. No c. Not sure

18. Is your child currently taking any prescribed medication (other than antibiotics)?

a. Yes b. No c. Not sure

19. Has your child taken any antibiotics in the last 12 months?

a. Yes b. No c. Not sure

19a. If yes, how many courses?

And for what:
a. Ear infection b. Skin infection c. Lung Infection d. Urine Infection e. Throat f. Sinus
g. Other Please specify

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

a. Yes b. No c. Not sure

21. Do you have a pet at home?

a. Yes b. No

21a. If yes, what kind?
a. Dog b. Cat c. Bird d. Fish e. Rabbit f. Other Please specify :

22. Is your child regularly being cared for by someone other than the mother or father?
a. Yes b. No c. Not sure

22a. If yes, where have they been receiving care?

a. Home b. Outside of home

23. Is your child enrolled in preschool program?

a. Yes b. No c. Not sure

24. Does your child have any siblings?

a. Yes b. No

24a. If yes, how many?

25. Does your child have any half-siblings?

a. Yes b. No

26. Does your child sleep through the night?

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

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

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

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

a. Yes b. No c. Sometimes

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

    a. Yes b. No c. Sometimes

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

    a. Yes b. No c. Not sure

2. Has your child been to a dentist?

    a. Yes b. No

3. How many cavities has your child had? ☐

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
Enjoys doing new things		
Plays "Mom" and "Dad"		
Is more and more creative with make-believe play		
Would rather play with other children than by himself		

Cooperates with other children		
Often can't tell what's real and what's make-believe		
Talks about what she likes and what she is interested in		
Knows some basic rules of grammar, such as correctly using "he" and "she"		
Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"		
Tells stories		
Can say first and last name		
Names some colors and some numbers		
Understands the idea of counting		
Starts to understand time		
Remembers parts of a story		
Understands the idea of "same" and "different"		
Draws a person with 2 to 4 body parts		
Uses scissors		
Starts to copy some capital letters		
Plays board or card games		
Tells you what he thinks is going to happen next in a book		
Hops and stands on one foot up to 2 seconds		
Catches a bounced ball most of the time		
Pours, cuts with supervision, and mashes own food		

The Childhood Autism Spectrum Test (CAST)
Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

1. Does s/he join in playing games with other children easily?	Yes	No
2. Does s/he come up to you spontaneously for a chat?	Yes	No
3. Was s/he speaking by 2 years old?	Yes	No
4. Does s/he enjoy sports?	Yes	No
5. Is it important to him/her to fit in with the peer group?	Yes	No
6. Does s/he appear to notice unusual details that others miss?	Yes	No
7. Does s/he tend to take things literally?	Yes	No
8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy's tea parties)?	Yes	No
9. Does s/he like to do things over and over again, in the same way all the time?	Yes	No
10. Does s/he find it easy to interact with other children?	Yes	No
11. Can s/he keep a two-way conversation going?	Yes	No
12. Can s/he read appropriately for his/her age?	Yes	No
13. Does s/he mostly have the same interests as his/her peers?	Yes	No
14. Does s/he have an interest which takes up so much time that s/he does little else?	Yes	No
15. Does s/he have friends, rather than just acquaintances?	Yes	No
16. Does s/he often bring you things s/he is interested in to show you?	Yes	No
17. Does s/he enjoy joking around?	Yes	No

18. Does s/he have difficulty understanding the rules for polite behavior? Yes No

19. Does s/he appear to have an unusual memory for details? Yes No

20. Is his/her voice unusual (e.g., overly adult, flat, or very monotonous)? Yes No

21. Are people important to him/her? Yes No

22. Can s/he dress him/herself? Yes No

23. Is s/he good at turn-taking in conversation? Yes No

24. Does s/he play imaginatively with other children, and engage in role-play? Yes No

25. Does s/he often do or say things that are tactless or socially inappropriate? Yes No

26. Can s/he count to 50 without leaving out any numbers? Yes No

27. Does s/he make normal eye-contact? Yes No

28. Does s/he have any unusual and repetitive movements? Yes No

29. Is his/her social behavior very one-sided and always on his/her own terms? Yes No

30. Does s/he sometimes say “you” or “s/he” when she/he means “I”? Yes No

31. Does s/he prefer imaginative activities such as play-acting or story-telling, rather than numbers or lists of facts? Yes No

32. Does s/he sometimes lose the listener because of not explaining what s/he is talking about? Yes No

33. Can s/he ride a bicycle (even if with stabilizers/training wheels)? Yes No

34. Does s/he try to impose routines on him/herself, or on others, in such a way that it causes problems? Yes No

35. Does s/he care how s/he is perceived by the rest of the group? Yes No

36. Does s/he often turn conversations to his/her favorite subject rather than following what the other person wants to talk about? Yes No

37. Does s/he have odd or unusual phrases? Yes No

SPECIAL NEEDS SECTION

Please complete as appropriate

38. Have teachers/health visitors ever expressed any concerns about his/her development? Yes No

If yes, please specify.....

39. Has s/he ever been diagnosed with any of the following?:

Language delay	Yes	No
Hyperactivity/Attention Deficit Disorder (ADHD)	Yes	No
Hearing or visual difficulties	Yes	No
Autism Spectrum Condition, incl. Asperger's Syndrome	Yes	No
A physical disability	Yes	No
Other (please specify): _____	Yes	No

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

Obesogenic question: (FNPA)

Directions: For each question, please select the answer that best represents your child/family.

	Almost Never	Sometimes	Usually	Almost Always
1. My child eats breakfast….				
2. Our family eats meals together…..				
3. Our family eats while watching TV …				
4. Our family eats fast food….				
5. Our family uses microwave or ready to eat foods …				
6. My child eats fruits and vegetables at meals or snacks…				
7. My child drinks soda pop or sugar drinks…				
8. My child drinks low fat milk at meals or snacks…				
9. Our family limits eating of chips, cookies, and candy…				
10. Our family uses candy as a reward for good behavior…				
11. My child spends less than 2 hours on TV/games/computer per day				
12. Our family limits the amount of TV our child watches…				
13. Our family allows our child to watch TV in their bedroom…				
14. Our family provides opportunities for physical activity				
15. Our family encourages our child to be active every day				
16. Our family finds ways to be physically active together …				
17. My child does physical activity during his/her free time…				
18. My child is enrolled in sports or activities with a coach or leader…				
19. Our family has a daily routine for our child's bedtime…				
20. My child gets 9 hours of sleep a night …				

Maternal / Paternal Health

- ☐ Please select any health conditions you have had and/or are currently experiencing: None
- ☐ Currently Pregnant
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid
- ☐ Heart Problems
- ☐ Asthma
- ☐ Genetic/Congenital Abnormality
- ☐ Skin Conditions
- ☐ Allergies
- ☐ Irritable Bowel
- ☐ Migraines
- ☐ Stress/ Anxiety
- ☐ Depression
- ☐ Mental Illness
- ☐ Alcohol or Drug Abuse
- ☐ Nutrition disorders
- ☐ Cancer Type: _____
- ☐ Other problems Please specify: _____

References

Scott FJ, Baron-Cohen S, Bolton P, Brayne C. The CAST (Childhood Asperger Syndrome Test): preliminary development of a UK screen for mainstream primary-school-age children. Autism 2002 Dec; 6(4). PMID

FNPA question are adopted from: http://www.myfnpa.org/