The First 1,000 Days of Life … And Beyond

Six years Survey

Child Growth & Development

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

2. How tall is your child? _____ inches

3. 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

4. Where was your child weighed/ measured?
   a. Medical office/clinic b. Home c. Not sure d. Other

5. Do you have concerns about your child's weight?
   a. Yes b. No c. Not sure

6. 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

   6a. If yes, how many times in the past 12 months?
   a. 0-2 b. 3-6 c. more than 6 times

7. Has your child visited an urgent care or emergency department?
   a. Yes b. No c. Not sure
   7a. If yes, how many times in the past 12 months?
   a. 0-2 b. 3-6 c. more than 6 times

8. Do you have concerns about your child's health?
   a. Yes b. No c. Not sure

9. Has your child been diagnosed by a health care provider with Asthma?
   a. Yes b. No c. Not sure

   9a. If yes to Asthma, please answer the following questions:

PROMIS (Patient-Reported Outcomes Measurement Information System) – Asthma Impact

Directions: Please respond to each question or statement by marking one box per row.

In the past 7 days…	Never	Almost Never	Sometimes	Often	Almost Always
1. My child felt scared that he/she might have trouble breathing because of asthma					
2. My child's chest felt tight because of asthma					
3. My child felt wheezy because of his/her asthma					
4. My child had trouble breathing because of his/her asthma					
5. My child had trouble sleeping at night because of asthma					
6. It was hard for my child to play sports or exercise because of asthma					
7. It was hard for my child to take a deep breath because of asthma					
8. My child's asthma bothered him/her					

10. Has your child been diagnosed by a health care provider with developmental delay?

a. Yes b. No c. Not sure

10a. If yes to developmental delay, has s/he ever been diagnosed with any of the following?:

Language delay	Yes	No
Learning Disability	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

11. Has your child been diagnosed by a health care provider with being overweight?
    a. Yes b. No c. Not sure

12. Has your child been diagnosed by a health care provider with any other medical condition or disorder?
    a. Yes [ ] b. No c. Not sure

13. Is your child currently taking any prescribed medication (other than antibiotics) ?
    a. Yes b. No c. Not sure

14. Has your child taken any antibiotics in the past 12 months?
    a. Yes b. No c. Not sure
    11a. 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 [ ]

15. Does your child take any "over-the-counter" medications on a regular basis?
    a. Yes b. No c. Not sure

16. Do you have a pet at home?
    a. Yes b. No
    16a. If yes, what kind?
    a. Dog b. Cat c. Bird d. Fish 5. Rabbit 6. Other Please specify : [ ]

<u>Dental</u>

1. Does your child brush/clean her 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? [ ]

PROMIS Parent Proxy Scale v1.0 – Global Health 7+2
Parent Proxy Global Health 7+2
Please respond to each question or statement by marking one box per row.

1. In general, would you say your child's health is	Excellent	Very Good	Good	Fair	Poor
2. In general, would you say your child's quality of life is					
3. In general, how would you rate your child's physical health?					
4. In general, how would you rate your child's mental health, including mood and ability to think?					
	Never	Rarely	Sometimes	Often	Always
5. How often does your child feel really sad?					
	Always	Often	Sometimes	Rarely	Never
6. How often does your child have fun with friends?					
7. How often does your child feel that you listen to his or her ideas?					
In the past 7 days…	Never	Almost Never	Sometimes	Often	Almost Always
8. My child got tired easily					
9. My child had trouble sleeping when he/she had pain					

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 …				

PROMIS (Patient-Reported Outcomes Measurement Information System) – Psychological Stress Experiences

Directions: Please respond to each question or statement by marking one box per row.

In the past 7 days…	Never	Rarely	Sometimes	Often	Always
1. My child felt stressed					
2. My child felt that his/her problems kept piling up					
3. My child felt overwhelmed					
4. My child felt unable to manage things in his/her life					
5. Everything bothered my child					
6. My child felt under pressure					
7. My child had trouble concentrating					
8. My child felt he/she had too much going on					

PROMIS (Patient-Reported Outcomes Measurement Information System) – Family Relationships

Directions: Please respond to each item by marking one box per row.

	Never	Rarely	Sometimes	Often	Always
1. My child felt he/she had a strong relationship with our family					
2. My child felt he/she was really important to our family					
3. My child felt he/she got all the help he/she needed from our family					
4. Our family and my child had fun together					

Parent Proxy Sleep Disturbance – Short Form 4a
Please respond to each question or statement by marking one box per row.

In the past 7 days…

	Never	Almost Never	Sometimes	Almost Always	Always
1. My child had trouble falling asleep.					
2. My child slept through the night.					
3. My child had a problem with his/her sleep.					
4. My child had trouble sleeping.					

Parent Proxy Sleep-Related Impairment– Short Form 4a
Please respond to each question or statement by marking one box per row.

In the past 7 days…

	Never	Almost Never	Sometimes	Almost Always	Always
1. My child was sleepy during the daytime.					
2. My child had a hard time concentrating because he/she was sleepy.					
3. My child had a hard time getting things done because he/she was sleepy.					
4. My child had problems during the day because of poor sleep.					

Maternal / Paternal Health

Please select any health conditions you or your child's father 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: _____

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.

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

If we do discover information that might be important to your child's health, we can report those results back to your child's doctor if you want us to. Please provide us the name and phone number of your child's doctor if you grant us permission to contact the doctor with any discoveries important to your child's health.

Doctor's Name: _____

Doctor's Phone number: _____